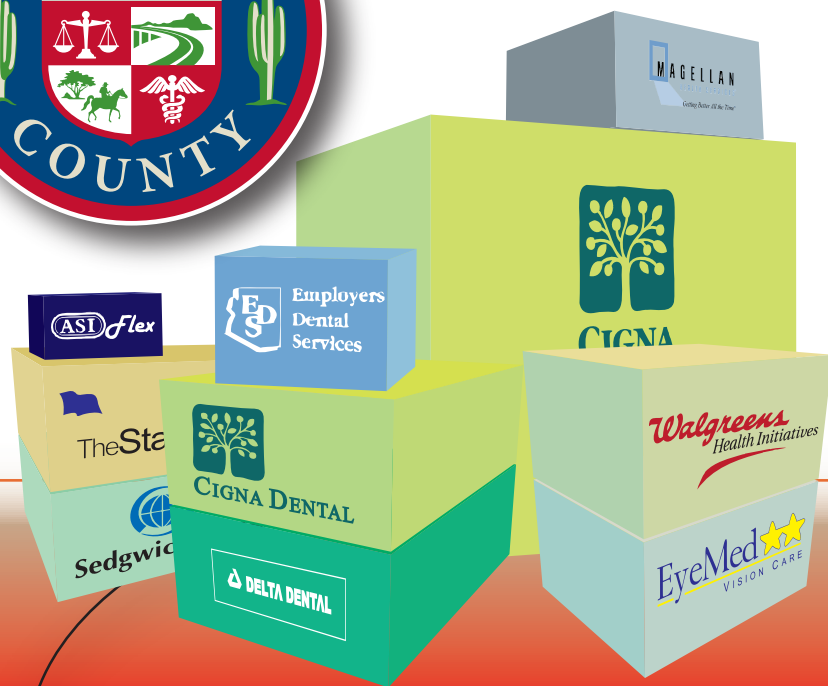


What's New? FY 08/09

**Open
Enrollment
April 14th
thru
May 2nd**



**Employee
Health
Insurance
Program**

What are the "Right" plans for you?



**Elect your
choices at:
my.maricopa.gov**

TABLE OF CONTENTS

Glossary of Terms	4
Glossary of Acronyms	5
How to Obtain Benefit Information	6
Disclaimer	6
Open Enrollment Period.....	7
What Happens If I Don't Complete Open Enrollment?	8
Pre-Enrollment Presentations	8
Open Enrollment Vendor Fairs.....	9
What's New?	
CIGNA Medical Plan changes.....	10
Pharmacy Plan changes	11
Behavioral Health changes	12
Dental Plan changes	12
Health & Wellness Initiatives	13
Premium Rate changes	14
Waiver Payment changes	14
Flexible Spending Account (FSA) Health Care Debit Card changes	14
Choosing The Plan That Suits You.....	15
Medical Plans	
Plan Summary Chart.....	16
Copay/Co-insurance Comparison Chart	18
Pharmacy Plans	20
Combined Rate Sheet	23
Dental	
Plan Summary Chart.....	24
Copay/Co-insurance Comparison Chart	25
How to look up a Physician or Dentist online	26
Vision	27
Life Insurance Plan.....	28
Mariflex Flexible Spending Accounts.....	30
What Is Short-Term Disability (STD)?	31
Other Benefits Offered	32
Open Enrollment Worksheet	33
Online Employee Self Service Instructions	34
Who To Contact.....	35



GLOSSARY OF TERMS

Biometric Screening Program: Provides employees with screenings for: Blood Pressure, Total/HDL Cholesterol and Ratio, Glucose, Height/Weight, Body Fat Analysis, Waist Circumference and One-on-one Health Coaching Session that includes program referrals and health education/literature on screening results.

CIGNA Care Network (CCN): A high performing cost effective specialty care provider network that includes the following provider specialties: allergy/immunology, pulmonology, vascular surgery, cardiology, neurosurgery, orthopedics and surgery, urology, general surgery, ear, nose and throat, ophthalmology, rheumatology, infectious disease, gastroenterology and dermatology. These providers are identified by a Tree of Life Symbol in the CIGNA provider directory.

CMG (CIGNA Medical Group Network): A network of providers who are employed by CIGNA HealthCare of AZ who practice in the CMG facilities that are owned and operated by CIGNA. Primary and some specialty and ancillary care are provided at the CMG facilities. Some specialty care is provided through the OAP network when a referral is made by the CMG physician.

CMG High and Low Plan: A managed-care plan that requires members to use the CMG facilities for primary and most specialty and other services. Use of non-network providers or providers who practice in their own offices are not covered.

Co-insurance: A cost-sharing requirement under a health insurance policy, which provides that the insured will assume a percentage of the costs of covered services after payment of the deductible, if applicable.

Copay: A cost-sharing arrangement in which the insured pays a specified flat dollar amount for a specific service (such as \$20 for an office visit). The amount does not vary with the cost of the service, unlike co-insurance, which is based on a percentage of cost.

Deductible(s): Under a health insurance policy, amounts required to be paid by the insured either before benefits become payable, after a portion of benefits have been paid or for a specific benefit, before benefits are payable.

Flexible Spending Account (FSA): A plan which provides employees with a way to set aside money on a pre-taxed basis to cover the costs of either health care expenses that are not covered under their health insurance coverage (medical, pharmacy, mental health, dental and vision) or dependent care expenses that enable the employee to work.

Group Insurance Qualified Status Change Form: A form provided by the EHI Department on which the employee requests to add or drop dependents due to a qualified status change.

Health Coaching Program: Coaches work one-on-one with employees to help identify goals and to embrace change.

Health Maintenance Organization (HMO): HMOs offer comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, e.g., physicians, hospitals and other health professionals, who participate in their network. The members of an HMO are required to use participating network providers for all health services, and many services must meet further approval by the HMO through its utilization review program. HMOs are the most restrictive form of managed care benefit plans because they manage and restrict the procedures, providers and benefits.

Health Risk Assessment (HRA): A brief online questionnaire that analyzes the health risk of the employee.

Health Savings Account: A tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan.

High Option: A plan where premiums are higher than a low option plan because the insured shares less of the costs with lower copays.

In-Network (or Network, Participating Provider): Health care provided by a doctor, hospital, pharmacy or other health care provider with whom the plan has contracted to provide services at specified fees.

Insured: A person or organization covered by an insurance policy.

Insurer (Insurance Company or vendor): A corporation, such as CIGNA HealthCare of Arizona, engaged primarily in the business of furnishing insurance to the public.

Low Option: A plan where premiums are reduced in comparison to a high option plan because the insured shares more of the costs in the form of higher copays and co-insurance.

Medical Waiver Payment: Compensation paid to the employee by the County if medical coverage is not elected because of enrollment in other eligible group health insurance. Waiving medical coverage means waiving coverage for all components of the medical plan, which includes medical, vision, pharmacy, and behavioral health and substance abuse benefits.

OAP (Open Access Plus) Plan: A plan that gives options to use a network or non-network physician/provider each time the insured needs medical care, and does not require a referral to see a specialist.

OAPIN (Open Access Plus) In-Network: A plan that uses a network of providers who practice in their own offices and independently contract with CIGNA. Non-network physicians/providers are not covered under this plan. The OAP In-Network also includes the CMG network. A referral is not required to see a specialist.

Out-of-Network (or Non-Participating, Non-Network Provider): Health care received from a provider who is not contracted with the insured's health plan network.

Out-of-Pocket Maximum: The maximum amount the insured pays each year for health care. The maximum may apply only to specific services such as inpatient hospitalizations. After this share of eligible expenses has reached the plan's out-of-pocket maximum per person or per family, the plan pays the full cost of eligible expenses for the rest of that plan year. The out-of-pocket maximum does not include any copays, pharmacy or mental health/substance abuse treatment expenses, or non-certification penalties. Each plan summary lists the expenses that count towards the out-of-pocket maximum.

Plan Year: July 1 through June 30

Preferred Medication List (aka Formulary): List of prescription drugs approved by a pharmacy benefit manager. Drugs on the preferred medication list are generally more cost effective and are as effective as other drugs that are non-preferred in the same therapeutic medication class. The list is available on the EHI Home Page.

Preventive Care Services: This includes all routine preventive services such as Well Baby Care, Well Child Care and Adult Preventive Care as identified by each plan in the plan summary.

Primary Care Physician (PCP): A physician who practices general medicine, family medicine, internal medicine or pediatrics.

Reasonable and Customary Charge (R&C): The prevailing charge of most other providers in the same or similar geographic area for the same or similar service. If the insured receives out-of-network services and the provider's fee is more than the R&C charge, the insured will have to pay the amount of charges above R&C. When care is received from an in-network provider, the eligible expenses are determined from the network provider's contracted rate.

Specialty Medication: Usually are expensive drugs (oral or injectable) that are used to treat complex and rare medical conditions. These drugs may require special care and handling (such as refrigeration) and patient counseling due to their high risk of causing serious side effects or complications.

Short-Term Disability (STD) benefits: STD pays a percentage of the insured's salary for up to 23 weeks after a 3-week waiting period if he/she becomes temporarily disabled due to sickness or injury and is not able to perform the essential functions of his/her job. The insured must be under the regular care and treatment of an appropriate provider.

Term Life Insurance: Term life insurance covers a person for death benefits for a limited time (a term). In the case of the term life insurance coverage provided by The Standard, the term is conditional. You are covered as long as you are employed by Maricopa County. Term life insurance does not have any cash value.

GLOSSARY OF ACRONYMS

Abbreviations used throughout this booklet

A

AD&D: Accidental Death & Dismemberment

AHCCCS: Arizona Health Care Cost Containment System

ARS: Arizona Revised Statutes

ASI: Application Software, Inc.

ASRS: Arizona State Retirement System

C

CCN: CIGNA Care Network

CMG: CIGNA Medical Group

COBRA: Consolidated Omnibus Budget Reconciliation Act

E

EAP: Employee Assistance Program

EBAC: Employee Benefits Advisory Council

EBC: Electronic Business Center (Intranet)

EDS: Employers Dental Services

EE: Employee

EHI: Employee Health Initiatives

EOI: Evidence of Insurability

F

FMLA: Family Medical Leave Act

FML: Family Medical Leave

FSA: Flexible Spending Account

H

HDL: High-density lipoprotein

HIPAA: Health Insurance Portability and Accountability Act

HMO: Health Maintenance Organization

HR: Human Resources

HRA: Health Risk Assessment

HSA: Health Savings Account

I

ID: Identification

IRC: Internal Revenue Code

IRS: Internal Revenue Service

L

LOA: Leave of Absence

M

MH: Mental Health

MST: Mountain Standard Time

N

NAIC: National Association of Insurance Commissioners

NEO: New Employee Orientation

NRS: Nationwide Retirement Solutions

O

OAPIN: Open Access Plus In-Network

OAP: Open Access Plus

OE: Open Enrollment

P

PCP: Primary Care Physician

PHI: Protected Health Information

PML: Preferred Medication List

PPO: Preferred Provider Organization

PSPRS: Public Safety Personnel

Retirement System

PST: Pacific Standard Time

PTO: Paid Time Off

R

RIF: Reduction in Force

RX: Prescription

S

SPD: Summary Plan Document

SSN: Social Security Number

STD: Short-Term Disability

U

UV: Ultraviolet

W

WHI: Walgreens Health Initiatives

HOW TO OBTAIN BENEFIT INFORMATION

Information about the benefit plans is available on the Internet at www.maricopa.gov/benefits or on the Electronic Business Center (EBC)/Intranet at ebc.maricopa.gov/ehi.

Both of these Web sites are referred to as the Employee Health Initiatives or EHI Home Page in this document.

You may also e-mail the EHI Department at BenefitsService@mail.maricopa.gov or, for enrollment and plan information, call 602-506-1010 from 8 a.m. to 5 p.m. MST Monday- Friday or visit the EHI Department located at 301 West Jefferson Street, Suite 201, Phoenix.

The EHI Department can assist you with general questions related to premiums, eligibility and enrollment, status changes, and benefits continuation while on or returning from a leave of absence (LOA) and/or upon retirement.

Please contact the specific vendor for answers to detailed benefit questions regarding coverage, costs and claim(s) payments. Vendor contact information is located in the "Who to Contact" section of this booklet.

The words "you" and "your," when used in this document, refer to the employee.

DISCLAIMER

Carefully read the information in this guide.

Do not make a medical or dental election solely on the basis of a healthcare provider's participation with the vendor's network because physicians and dentists may stop participating during the plan year. If a specific physician or dentist is very important to you, consider selecting a product with out-of-network benefits such as an Open Access Plus (OAP) High or Low option or Choice Fund PPO medical plan and/or CIGNA or Delta Dental plans. Plans with out-of-network benefits allow you to see providers who no longer participate with the vendor's network, at higher out-of-pocket costs to you. Additionally, you should not make your pharmacy election solely on the basis of specific medications on the preferred medication list because medication coverage status may change during the plan year. For example, medications may change from preferred brand name level to a generic or non-preferred brand name level, or may become available over-the-counter and therefore will not be covered under the pharmacy benefit.

Make your election decisions carefully as they cannot be changed until July 1, 2009. You may change your Open Enrollment elections online as many times as you want during the Open Enrollment period. However, changes to your elections cannot be accepted past the Open Enrollment closing date of May 2, 2008.

Complete your benefit elections in Employee Self Service no later than 5 PM, May 2, 2008. Once all enrollment elections are finalized by EHI following May 2, 2008, confirmation statements will be produced and delivered to you June 2008.

**PRINT YOUR BENEFITS OPEN ENROLLMENT SUMMARY PAGE FROM
EMPLOYEE SELF SERVICE AS YOUR VERIFICATION OF YOUR OPEN ENROLLMENT ELECTIONS.
KEEP THIS PAGE FOR VERIFICATION PURPOSES TO COMPARE
WITH YOUR CONFIRMATION STATEMENT IN THE EVENT OF AN ERROR.**

Review your confirmation statement immediately and contact EHI no later than June 30, 2008, if you discover an error. Only errors will be corrected. Your printed Benefits Open Enrollment Summary page from Employee Self Service will be accepted as verification of your Open Enrollment elections in the event of an error.

PCP changes are not available through Employee Self Service during Open Enrollment. Watch for your new ID card in the mail and upon receipt, be sure to check the PCP. After July 1, 2008, contact your selected medical plan vendor to change your primary care provider (PCP), if applicable. Destroy your old ID card upon receipt of your new card. If additional cards are needed, contact the vendor directly either by phone or through their Web site. See the "Who to Contact" section.

OPEN ENROLLMENT PERIOD

This Open Enrollment period, your benefit elections and premium rates are effective for a 12-month period, beginning July 1, 2008 and ending June 30, 2009. The next time you can change your benefits will be the next Open Enrollment in April 2009. All benefit-eligible full and part-time employees scheduled to work at least 20 hours per week, elected officials, and contract employees with benefits are eligible to complete Open Enrollment.

WHEN?

The Open Enrollment system will be available 8 AM, Monday, April 14 through 5 PM, Friday, May 2, 2008

It is recommended that you not delay in completing your Open Enrollment elections in the event you encounter system-related problems or problems finding your password. Your Open Enrollment information must be entered online in Employee Self Service no later than 5 PM, May 2, 2008. **Late enrollments will not be accepted.**

HOW?



Online via Employee Self Service available through the EBC Intranet or the Internet at my.maricopa.gov

If you do not have access to a computer, check with your department HR Liaison for information about computer resources that will be available for your use. Computers are also available at most public libraries.

1. Have your User ID and password ready
2. Type my.maricopa.gov into your browser address bar
3. Sign in using your User ID and password
4. Click on the PeopleSoft link
5. Click on the Human Resources 8.8 link (opens another window)
6. Close the first window
7. Click on Employee Self Service
8. Click on the Benefits link
9. Click on Enroll in Benefits
10. Choose your Benefits
11. Submit your elections
12. Print the enrollment summary page as your confirmation

Refer to page 33 for detailed instructions

WHAT DO YOU DO IF YOU DON'T KNOW YOUR USER ID OR PASSWORD?

Call your department PC Help Desk or the Customer Support Center at (602) 506-4357 between 6:30 AM-6 PM, Monday-Friday for assistance or to reset your password.

WHERE DO I GET ADDITIONAL INFORMATION NOT CONTAINED IN THIS GUIDE?

While most of the information you need is contained in this guide, other pertinent information is available online at the Benefits Home page located at <http://www.maricopa.gov/benefits> (Internet) or <http://ebc.maricopa.gov/ehi> (Intranet). The Benefit vendors are your primary and best source of information regarding the plans they offer. Refer to the "Who to Contact" section for their telephone numbers and Web site addresses.

WHEN WILL I RECEIVE NEW INSURANCE ID CARDS?

- New CIGNA Medical ID cards will be issued to all enrollees for all medical plans, except for current enrollees in the Choice Fund HSA plan. CIGNA issues an individual ID card for each enrollee.
- New ID cards will be issued to new enrollees in the pharmacy or vision benefit, and EDS or Delta Dental plans. The ID cards from these vendors either 1) contain the names of all covered dependents or 2) contain only the insured's name and can be used for all covered dependents.
- There are no personalized ID cards for Magellan Health Services or CIGNA Dental. These ID cards are available through the Employee Health Initiatives Department.

WHAT HAPPENS IF I DON'T COMPLETE OPEN ENROLLMENT?

HEALTH & WELLNESS INCENTIVES

If you do not complete Open Enrollment, it will be assumed that you are not voluntarily participating in the Biometric Screening and Health Risk Assessment Initiatives, and therefore, will not receive the financial incentives.

TOBACCO USER RATES

If you do not complete Open Enrollment, it will be assumed that your current status as a tobacco user is correct. Please note that the tobacco user rates apply not only to the employee but also to any covered dependent. **If you have a covered dependent who uses tobacco products and you do not, you must complete open enrollment to update this information.** If you have not elected benefits before, it is assumed you and/or your covered dependents are tobacco users and you will be charged a higher premium, unless you change the tobacco use indicator. Employees who do not provide accurate information will be subject to disciplinary action up to and including termination.

MARIFLEX FSA

If you do not complete Open Enrollment, you will not be enrolled in the flexible spending accounts. You must re-enroll in the Mariflex election every Open Enrollment.

MEDICAL, DENTAL, PHARMACY, VISION, BEHAVIORAL, LEGAL, LIFE & SHORT-TERM DISABILITY

You are encouraged to go online to review your current benefit elections. If you do not enroll, you and your current dependents will be enrolled in your current medical, dental, pharmacy, vision, behavioral health, group legal, life insurance and short-term disability benefit plans.

WAIVER

If you are currently receiving the medical waiver payment and you don't enroll, you will continue receiving the medical waiver payment. Verification of current coverage through other group health insurance is required to be sent to the EHI Department by May 30, 2008.

(Maricopa County will compensate you \$100 per month if you work at least 30 hours per week and waive your medical coverage.

To qualify, you must be covered under other group health coverage and provide proof of the group health insurance coverage to EHI on an annual basis. Arizona Health Care Cost Containment System (AHCCCS) coverage does not qualify as group health insurance and does not qualify you to waive your group medical benefits in order to be eligible for the waiver payment. Employees who receive the waiver payment may enroll in the stand-alone vision plan, dental, and/or additional life insurance.)

PRE-ENROLLMENT PRESENTATIONS

To learn more about the benefit offerings, please attend one of the Pre-Enrollment Sessions. Registration is not required.

During each session, various benefit vendors will present an overview of their plans.

Date	Location	Address	Time
Wednesday, April 2	Juvenile Court (Southeast Facility)	1810 S. Lewis Saguario Room	8 AM - 5 PM
Thursday, April 3	Juvenile Probation	3125 W. Durango St. Training Rm # 1	8 AM - 5 PM
Friday, April 4	Correctional Health (Lower Buckeye Jail)	3250 W. Lower Buckeye RTC Conf. Rm, 2nd Floor	8 AM - 5 PM
Monday, April 7	Department of Transportation	2901 W. Durango St. Apache/Cochise Conf. Rm	8 AM - 5 PM
Tuesday, April 8	Probation Service Center	245 N. Centennial Way Events Rm	8 AM - 5 PM
Wednesday, April 9	Facilities Management	401 W. Jefferson Freedom Rm	8 AM - 12:30 PM
Thursday, April 10	Planning and Development	501 N. 44th St. Gold/Platinum Rm	8 AM - 5 PM
Friday, April 11	Correctional Health (4th Avenue Jail)	201 S. 4th Ave. 1st Floor Conf. Rm	8 AM - 5 PM

Daily Vendor Schedule	
8:00 AM	CIGNA HealthCare (Medical/Dental)
9:30 AM	Employers Dental Services (Dental)
10:30 AM	Delta Dental (Dental)
11:30 AM	Walgreens Health Initiatives (Pharmacy)
12:30 PM	CIGNA HealthCare (Medical/Dental)
2:00 PM	Employers Dental Services (Dental)
3:00 PM	Delta Dental (Dental)
4:00 PM	Walgreens Health Initiatives (Pharmacy)

OPEN ENROLLMENT VENDOR FAIRS

EHI is hosting vendor fairs at the following locations on the dates and times listed. Please plan to visit a fair to receive vendor information or to have your specific benefit questions answered by the vendors.

Date	Location	Address	Time
Monday, April 14	Administration Building	301 W. Jefferson St., Breezeway, 2nd Floor	11 AM - 1 PM
Tuesday, April 15	Security Building/Human Services	222 N. Central Ave., Arizona Conf. Rm, 3rd Floor	9 AM - 11 AM
Tuesday, April 15	Downtown Justice Center	620 W. Jackson St., Training Rm 1-2	2 PM - 4 PM
Wednesday, April 16	Planning & Development	501 N. 44th St., Gold/Platinum Rm	10 AM - 12 PM
Thursday, April 17	Public Health Administration Building	4041 N. Central Ave., 14th Floor Training Rm	10 AM - 12 PM
Monday, April 21	Juvenile Court Ctr. Southeast Facility	1810 S. Lewis, Cactus Rm	9 AM - 11 AM
Tuesday, April 22	Department of Transportation	2901 W. Durango St., Apache/Maricopa Conf. Rm	11 AM - 4 PM
Wednesday, April 23	East Court Building	101 W. Jefferson, Law Library, Cordova Rm. 3rd Floor	11 AM - 1 PM
Thursday, April 24	Air Quality/Environmental Services	1001 N. Central Ave., Training Rm, 5th Floor	9 AM - 11 AM
Thursday, April 24	Security Building/Human Services	222 N. Central Ave., Arizona Conf. Rm, 3rd Floor	2 PM - 5 PM
Tuesday, April 29	Public Health Clinic	1645 E. Roosevelt St., Garfield Rm	10 AM - 12 PM
Tuesday, April 29	Animal Care & Control	2500 S. 27th Ave., Rm 102 & 103	2 PM - 4 PM
Wednesday, April 30	Probation Service Center	245 N. Centennial Way, Events Rm	11 AM - 1 PM
Thursday, May 1	Administration Building	301 W. Jefferson St., Breezeway, 2nd Floor	9 AM - 11 AM
Thursday, May 1	Juvenile Probation	3125 W. Durango St., Training Rm 1-3	2 PM - 5 PM
Friday, May 2	Human Services/Head Start	2150 S. Country Club Way, Ste. #7, Tucson B Room	2 PM - 4 PM

QUESTIONS?

Refer to the contact information page provided at the end of this booklet

Call the Employee Health Initiatives Department at
(602) 506-1010 from 8 AM to 5 PM Monday-Friday for benefit questions.

For questions on how to use Employee Self Service to make your Open Enrollment elections once you are logged on, contact your department's HR Liaison.

WHAT'S NEW?

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2008 THROUGH JUNE 30, 2009

CIGNA MEDICAL PLAN CHANGES

Changes to the medical plan offerings and copayments are listed below.

CMG (CIGNA Medical Group) High Option changes		
Service	Copay	Change
Preventive Care	\$0	Was \$15 / \$25
Allergy Injections	\$8* / \$23	Was \$25
Specialty Care	\$25* / \$40	No change / Was \$25
Emergency Room	\$125	Was \$75

CMG (CIGNA Medical Group) Low Option changes		
Service	Copay	Change
Preventive Care	\$0	Was \$25 / \$45
Allergy Injections	\$13* / \$28	Was \$45
Specialty Care	\$45* / \$60	No Change / Was \$45
Emergency Room	\$125	Was \$100

OAPIN (Open Access Plus In-Network) changes		
Service	Copay	Change
Preventive Care	\$0	Was \$20 / \$30
Allergy Injections	\$10* / \$25	Was \$30
Specialty Care	\$30* / \$45	No Change / Was \$30
Emergency Room	\$125	Was \$100

OAP (Open Access Plus) High Option changes		
In-Network Service	Copay	Change
Preventive Care	\$0	Was \$25 / \$35
Allergy Injections	\$13* / \$28	Was \$35
Specialty Care	\$35* / \$50	No change / Was \$35
Emergency Room	\$125	Was \$100

OAP (Open Access Plus) Low Option changes		
In-Network Service	Copay	Change
Preventive Care	\$0	Was \$35 / \$50
Allergy Injections	\$18* / \$33	Was \$50
Specialty Care	\$50* / \$65	No change / Was \$50
Emergency Room	\$150	No Change


Choice Fund HSA (Health Savings Account) changes		
	In-network & out-of-network	Change
Single Coverage	\$2,000	Was \$5,000
Other Coverage Levels	\$4,000	Was \$10,000

Preventive Care Services - \$0 Office Visit Copay

This only applies to in-network services and includes the following:

- Routine Preventive Care for children and adults
- Routine Immunizations
- Routine Mammograms, PSAs, and Pap Smears

****CIGNA Care Network Specialist - Specialty Care Services - \$15 Office Visit Copay Differential***

When selecting in-network Specialty Care through a CIGNA Care Network (CCN) provider, the office visit is offered at a lower copayment. The CIGNA Care Network is a high-performing cost-effective specialty care network that meets certain criteria related to quality and efficiency. The CCN includes the following provider specialties: allergy/immunology, pulmonology, vascular surgery, cardiology, neurosurgery, orthopedics and surgery, urology, general surgery, ear, nose and throat, ophthalmology, rheumatology, infectious disease, gastroenterology and dermatology. CCN providers are identified by a Tree of Life Symbol  when you go online to www.cigna.com to search for a provider. This office visit copayment differential does not apply to the CIGNA Choice Fund HSA plan.

Durable Medical Equipment – No Annual Limit

For in-network services, there is no annual limit for Durable Medical Equipment. All Durable Medical Equipment must be medically necessary and a prior authorization is required for certain equipment.

Allergy Injections – Lower Office Visit Copay

For in-network services, a lower office visit copay applies for Allergy Injections administered by your Primary Care or CIGNA Care Network (CCN) Specialty Care Provider. Allergy Injections received from a non-CCN Specialty Care Provider are \$15 higher. This lower office visit copay does not apply to the CIGNA Choice Fund HSA plan.

WHAT'S NEW? continued

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2008 THROUGH JUNE 30, 2009

CIGNA Healthy Pregnancies, Healthy BabiesSM

While most women have a healthy, uncomplicated pregnancy, others may need specialized care to deliver a healthy baby. Through a comprehensive maternity support program, CIGNA supports all pregnant members and members considering pregnancy, whether they simply need information about pregnancy and babies, or are identified as high-risk and need specialized case management. This program includes pre-conception and prenatal education through print and web-based tools, a comprehensive assessment and development of individualized care plans tailored to each member's specific needs. An incentive is available at program completion based on your stage of pregnancy when you enroll in the program. If you enroll in the first trimester you will receive \$150 or \$75 for second trimester enrollment.

To enroll, call (800) 244-6224, on or after July 1, 2008 and ask to enroll in the [CIGNA Healthy Pregnancies, Healthy BabiesSM Program](#).

Information regarding this program is available on the Benefits/EHI Home Page ebc.maricopa.gov/ehi.

Choice Fund Health Savings Account Plan

Cross Accumulation for deductibles and out-of-pocket maximums

If a service is received in-network or out-of-network, the covered costs will be applied to both your in-network and out-of-network deductible and out-of-pocket maximums.

Out-of-pocket maximums reduced

Reduced the out-of-pocket maximums from \$5,000 to \$2,000 for single coverage and from \$10,000 to \$4,000 for all other coverage levels.

PHARMACY PLAN CHANGES

Healthy Living Diabetes Care Management Program

Employees and their dependents who voluntarily enroll in and complete the requirements of the [Diabetic Management Program](#) managed by the Employee Health Initiative's Department will be eligible to enroll in the [Healthy Living Diabetes Care Management Program](#). Upon program completion participants will be reimbursed for up to 9 diabetic-related office visit copays per plan year. This Program consists of a comprehensive educational program provided collaboratively by Walgreens Health Initiatives and the Joslin Diabetes Center, the global leader in diabetes research, care, and education, dedicated to improving health outcomes for people with diabetes. Call 602-506-3758 to enroll.

Information regarding this program is available on the Benefits/EHI Home Page ebc.maricopa.gov/ehi.

Delivery of Specialty Medication

Specialty medication will be delivered only through Walgreens Specialty Pharmacy, a centralized mail order distribution center. Walgreens Specialty Pharmacy offers personalized care from an experienced Care Team of pharmacists and nurses trained in the complex health conditions and the latest medication therapies. A wide range of support services will be available to assist you with your specialty medication needs. Through these support services, you will receive personalized support that can help you get the best results from your prescribed therapy. These services are available to you at no cost. Employees and/or dependents impacted by this change will receive a letter in May 2008.

Information regarding this program is available on the Benefits/EHI Home Page ebc.maricopa.gov/ehi.

Changes that apply to the Co-Insurance Pharmacy Plan

Non-Sedating Antihistamine (NSA) Step Care Therapy Program

A Non-Sedating Antihistamine Step Care Therapy Program will be implemented. This program includes the following non-sedating antihistamine (NSA) medications: Allegra, Allegra-D® 12 Hour, Allegra-D® 24 Hour, fexofenadine, Clarinex®, Clarinex-D® 12 Hour, Clarinex-D® 24 Hour, Clarinex-D® Reditab, or Xyzal®. This Step Care Therapy Program requires you to first try the over-the-counter options—Claritin (loratadine) and Zyrtec (cetirizine)—before filling a prescription for a NSA medication. In many cases, these over-the-counter NSA medications are as effective as the prescription NSA medications, and cost less for you and your dependents.

If you or your dependents have already tried an over-the-counter NSA and your doctor says you require a prescription NSA, please call the WHI Clinical Call Center at (877) 665-6609, Monday through Friday, 8:00 AM - 8:00 PM CDT, to start the prior authorization process. Employees who are impacted by this change, will receive a letter by June 2008.

Xyzal® will be considered Tier 3 or Non-Preferred Brand

In addition, Xyzal® will be considered Tier 3 or non-preferred brand on the Preferred Medication List (PML) and will be subject to the highest co-insurance level. A 30-day supply of a non-preferred drug with no generic equivalent such as Xyzal will have a 50% co-insurance. The lower cost, Tier 1, generic alternative is fexofenadine.

WHAT'S NEW? continued

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2008 THROUGH JUNE 30, 2009

BEHAVIORAL HEALTH CHANGES

Confidential Health Coaching Program

To encourage behavior change that can mitigate the risk associated with certain high risk conditions, a health coaching program will be implemented by Magellan Health Services. Based on the results of your Biometric Screening, you may receive a call from a health coach. The health coaching program provides you with your own personal coach who will assist you in developing lasting healthy behaviors.

A personal health coach can help you:

- Develop a personal action plan that fits your lifestyle;
- Overcome your personal challenges; and
- Stay motivated with one-on-one support and encouragement

Each telephonic session usually lasts about 20-30 minutes, and you will have the same coach. There is no cost to you and participation is voluntary. Self-referral into the Health Coaching program is not available. More information regarding this program is available on the Benefits/EHI Home Page at ebc.maricopa.gov/ehi.

DENTAL PLAN CHANGES

CIGNA Dental Progressive/Regressive Feature

The CIGNA Dental plan will be enhanced to include a progressive/regressive wellness incentive that will apply to dental services provided in-network and out-of-network. Preventive care services received in one plan year are rewarded with higher benefit percentages the next plan year. The benefit level increases year after year as employees and/or dependents receive preventive care. When preventive care is not received, the benefit percentage decreases in the following year; however, the benefit percentages will never fall below the base plan design which is effective 07/01/08.

The plan is designed to encourage good dental care for you and/or your dependents. Therefore, the increase/decrease (progression/regression) in benefit is tracked at an individual member level and the increase only applies to those family members that receive Preventive Care Services.

The base plan summary by class for Year One, effective 07/01/08, is defined below. For a detailed benefits summary, please turn to page 24.

Year One - Effective 7/01/08 - Base Plan

Benefit Level	In-Network		Out-of-Network	
	Plan	Employee	Plan	Employee
Class I - Preventive & Diagnostic Care	100%	0%	80%	20%
Class II - Basic Restorative Care	80%	20%	60%	40%
Class III - Major Restorative Care	50%	50%	50%	50%
Class IV - Orthodontia	50%	50%	50%	50%

Progressive Feature

Preventive Care Services (Class I) received in Year One are rewarded with high benefit percentages for Basic Restorative Care (Class II) and Major Restorative Care (Class III) for both in-network and out-of-network services. Progression increments are 5% per year and will not exceed the maximum benefit level in Year Three, which is 90% (in-network) and 70% (out-of-network) for Class II and 60% Class III (in- and out-of-network).

For example, if you receive Preventive Care Services (Class I) during Year One (Base Plan), your plan design for Year Two is defined below:

Year Two - Effective 7/01/09

Benefit Level	In-Network		Out-of-Network	
	Plan	Employee	Plan	Employee
Class I - Preventive & Diagnostic Care	100%	0%	80%	20%
Class II - Basic Restorative Care	85%	15%	65%	35%
Class III - Major Restorative Care	55%	45%	55%	45%
Class IV - Orthodontia	50%	50%	50%	50%

WHAT'S NEW? continued

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2008 THROUGH JUNE 30, 2009

If you receive Preventive Care Services (Class I) during Year Two, your plan design for Year Three is defined below:

Year Three - Effective 7/01/10

Benefit Level	In-Network		Out-of-Network	
	Plan	Employee	Plan	Employee
Class I - Preventive & Diagnostic Care	100%	0%	80%	20%
Class II - Basic Restorative Care	90%	10%	70%	30%
Class III - Major Restorative Care	60%	40%	60%	40%
Class IV - Orthodontia	50%	50%	50%	50%

REGRESSIVE FEATURE

When Preventive Care Services (Class I) are not received, the benefit percentages for Basic Restorative Care (Class II) and Major Restorative Care (Class III) will decrease the following year. Regression decrements are 5% and will not fall below the Base Plan Year.

ILLUSTRATIONS

Below are 3 different illustrations:

ILLUSTRATION 1

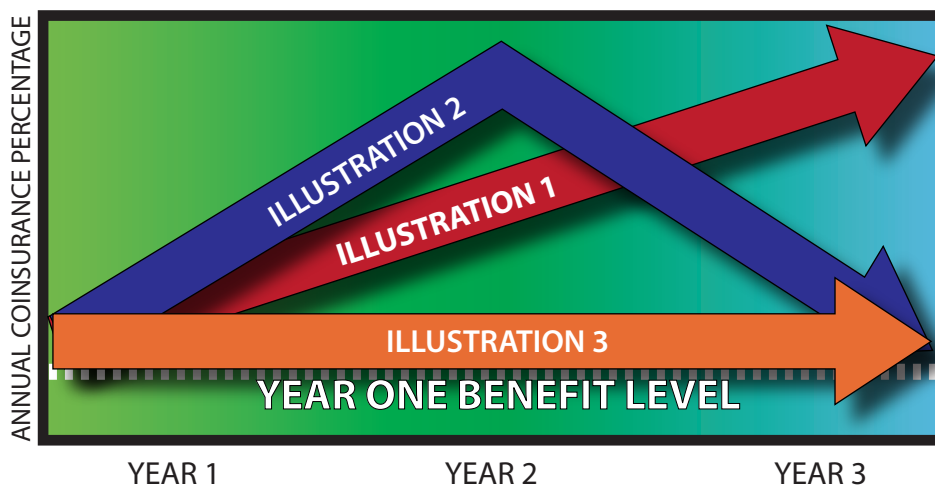
If you receive preventive care every plan year, your benefit level will increase the following plan year until it reaches the maximum level - year 3.

ILLUSTRATION 2

If you receive preventive care in plan year 1, your benefit level will increase in year 2. If you do not receive preventive care in year 2, your benefit level in year 3 will return to year 1 benefit level.

ILLUSTRATION 3

If you never receive preventive care, your benefit level will remain the same and never decrease below your base plan year.



HEALTH & WELLNESS INITIATIVES

Employees enrolled in a County medical plan (not including dependents) voluntarily participating in the new health and wellness initiatives for free biometric screening and a health risk assessment will save \$240 per plan year on their County medical insurance premium.

In order to receive the County medical insurance savings for the new plan year, effective July 1, 2008, you must complete these voluntary initiatives before May 2, 2008 and before you complete your online Open Enrollment elections.

Should you decide not to participate by May 2, 2008, these new initiatives will be available throughout the year on a limited basis. However, savings will be processed on a prospective basis after July 1, 2008.

WHAT'S NEW? continued

ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2008 THROUGH JUNE 30, 2009

Confidential Biometric Screening Initiative

Biometric Screening consists of completing a brief personal health history as well as having your measurements taken for height, weight, waist circumference, body fat composition, cholesterol and glucose levels, and blood pressure. Your confidential results will be discussed with you by a health educator at the end of the screening process.

Based on the results of your Biometric Screening, a health coach provided by Magellan Health Services may call you. The Magellan Health Coaching program is a voluntary, confidential program offered at no cost to you. The program provides a coach who will work one-on-one with you to identify and achieve your health and wellness goals.

Screenings will be performed by appointment only at several worksite locations and at some of the CIGNA Medical Group Centers. A schedule of all locations is available on the Electronic Business Center (EBC) EHI Home Page. To make an appointment, you can either go online at www.EHMS.com or call (480) 827-2277. Phone lines will be in operation Monday – Friday, between the hours of 8AM – 5PM.

Health Risk Assessment Initiative

A brief 15-minute online Health Risk Assessment consists of a series of questions that you answer about your health and lifestyle. Your confidential responses are then assessed by the WebMD application to determine your health risks. Your confidential results provide you with information that may provide you with insight or answers on ways you can improve your health. The Health Risk Assessment is available online through www.mycigna.com and should be taken **after** your Biometric Screening appointment so that you can enter your screening results.

If you are not registered with www.mycigna.com, registration instructions are available on the EHI Home page under the Open Enrollment tab. If you have registered, but cannot locate your User ID or password, or if you are having any trouble with the system, call the Internet Customer Service line 800-284-8386.

Instructions for how to access the Health Risk Assessment tool on www.mycigna.com are also available on the EHI Home page.

PREMIUM RATE CHANGES

- The premium discount has been increased from \$10.00 to \$15.00 per pay period for non-tobacco using households (employees and their dependents). Households where either the employee and/or a covered dependent uses tobacco-products, do not qualify for the discount and will be charged a premium rate this \$15 per pay period higher.
- Employees voluntarily participating in the new health and wellness biometric screening and health risk assessment initiatives will save \$240 per year on their medical insurance premiums. Employees who do not participate in these initiatives will be charged a premium rate that is \$5 per pay period higher for each initiative.
- The premium rate for contract employees will be limited to the part-time rates.
- The premium rate for part-time employees will be limited to the part-time rates.
- Premium rates have changed. Some rates have increased while others have decreased. Review each benefit and the corresponding rate. There is also a rate schedule that shows the combined rates which include medical, behavioral health, pharmacy and vision.

WAIVER PAYMENT CHANGES

The compensation for waiving Maricopa County's group medical insurance when covered by other group medical insurance will be decreased from \$125 a month to \$100 a month.

FLEXIBLE SPENDING ACCOUNT (FSA) HEALTH CARE DEBIT CARD CHANGES

A new and improved debit card that can be used for medical, pharmacy, dental, vision and FSA-approved over-the-counter health items will be available July 1, 2008. The card pays the provider for the care or item and your available FSA balance is reduced by the purchase amount. Follow-up claim documentation will be required for some charges.

If purchasing medication in a three-month supply is financially problematic, please consider enrolling in either the Choice Fund HSA medical plan that uses the CIGNA pharmacy plan and does not require you to purchase maintenance medication in three-month quantities, or enrolling in the Health Care FSA (Flex Spending Health Care) and requesting a debit card (requires an additional fee of \$0.75 per pay period). The debit card allows you to pay for your medication in advance up to your annual pre-tax Flexible Spending Account contribution in advance of collecting your full annual contribution. Contact ASI for specific details.

CHOOSING THE PLAN THAT SUITS YOU

Maricopa County is committed to promoting better health for its employees and their families by continually evaluating our employee health benefits. Furthermore, Maricopa County continually looks for innovative solutions that will help all of us effectively control short and long-term health care costs without sacrificing the quality of health care you and your family deserve. We believe that by providing a wide selection of medical insurance benefit options every employee has the opportunity to choose the “**right plan**” for their family.

To help you decide what medical plan is “**right for you**”, please consider the following questions in the tables below. Table A is specific to the High Deductible Health Plan (HDHP) with Health Savings Account benefit option, and Table B applies to all managed care medical options. Please take the time to review both tables and review the plans for which you are interested.

TABLE A - IS THE CHOICE FUND HEALTH SAVINGS ACCOUNT BENEFIT OPTION RIGHT FOR YOU?	
Do you consider yourself to be healthy?	Yes / No
Do you enjoy managing and investing your money in programs like Deferred Compensation or other investments vehicles and watching the balance grow over the years?	Yes / No
Are you interested in having funding available to help save for future qualified medical and retiree health expenses on a tax-free basis?	Yes / No
Did you attend a Health Savings Account Benefit Option class offered by Maricopa County and CIGNA?	Yes / No

If you answered Yes more than twice, please turn to the Medical Plan Summary Chart for more information on the CIGNA Choice Fund HSA plan benefit option.

TABLE B - FIND THE MEDICAL PLAN THAT’S BEST FOR YOU!	
Will you and/or your covered dependents live outside of Maricopa County during the plan year?	Plans
The OAP High and Low options as well as Choice Fund HSA offer out-of-network benefits and national networks of providers. The OAP In-Network option uses a national network of providers.	OAPIN OAP High OAP Low HSA
Do you like to use the CIGNA Medical Centers exclusively for your primary care needs?	
If you enjoy the convenience of receiving your primary medical care through a CIGNA Medical Center (owned and operated by CIGNA), you may want to consider the CMG High or Low benefit options.	CMG High CMG Low
Is your per paycheck deduction (cost) the most important criterion when deciding which medical benefit option to choose?	
If the amount of your paycheck deduction is more important to you than your out-of-pocket costs, such as copays, there are many benefit options to choose from. Some of the lowest per paycheck deductions are for the CMG Low, CMG High and the Choice Fund HSA benefit options.	CMG High CMG Low HSA
Do you prefer lower out-of-pocket costs (copays and co-insurance) when deciding which medical benefit option to choose?	
Lower out-of-pocket costs, such as copays, mean that your per paycheck deduction will be higher. CMG High and OAP In-network benefit options offer lower copays.	CMG High OAPIN
Are your doctors and hospitals covered under the medical benefit option you choose?	
For all benefit options, CIGNA contracts with a variety of medical providers for different services that includes doctors, hospitals, laboratories, etc. Some benefit options offer larger networks that includes private practice primary care physicians and national networks to cover out-of-area services. The OAP In-network, OAP Low, OAP High and CIGNA Choice Fund HSA benefit options offer large provider networks.	OAP Low OAP High OAPIN HSA
Do you like having the flexibility of seeing providers who are outside of the plan’s network?	
The OAP Low, OAP High and Choice Fund HSA benefit options offer coverage of providers who are not in the plan’s network.	OAP High OAP Low HSA
Is having direct access to network providers without a referral important to you?	
For the OAP In-Network, OAP Low, OAP High and Choice Fund HSA benefit options, NO referrals to network specialists or PCP designation is necessary.	OAPIN OAP High OAP Low HSA

Find out how the medical plans work and compare plans to determine which plan works best for you.

Logon to www.mycignaplans.com

username: Maricopa2008

password: cigna

MEDICAL PLAN SUMMARY CHART

Benefit Provision	CIGNA Medical Group High (CMG High):		CIGNA Medical Group Low (CMG Low):		Open Access Plus In-Network (OAPIN):	
Type of Plan	<u>HMO</u>		<u>HMO</u>		<u>HMO</u> with Open Access to Specialists	
Service Area Where Care Must be Received	Maricopa County only, except for emergency care		Maricopa County only, except for emergency care		Nationally	
Residency Requirement	Must work or reside in Maricopa County		Must work or reside in Maricopa County		None	
Primary Care Physician (PCP) Required	Yes; May only use PCP's who practice in CIGNA Medical Group Centers		Yes; May only use PCP's who practice in CIGNA Medical Group Centers		No	
Referral Required	Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine		Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine		No	
Out-of-Network Coverage	No		No		No	
Network	AZ-CIGNA Medical Group Network AZ812		AZ-CIGNA Medical Group Network AZ812		National Open Access Plus AZ300	
Prior Authorization	Provider's responsibility		Provider's responsibility		Provider's responsibility	
Per Pay Period (24/yr.) Medical Premiums**	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Employee	\$5.92	\$85.38	\$4.34	\$60.28	\$11.96	\$86.94
Employee + Spouse	\$22.14	\$95.28	\$17.12	\$71.40	\$55.12	\$96.74
Employee + Child(ren)	\$12.16	\$92.38	\$9.36	\$68.92	\$39.34	\$94.10
Employee + Family	\$38.24	\$99.42	\$29.16	\$73.36	\$81.70	\$100.96

**These premiums are based on all participants being tobacco free and employee voluntarily participating in the biometric screening and Health Risk Assessment initiatives. Medical premiums also include the behavioral health premium. Add \$15 per household for tobacco-users (employees and/or covered dependents). Add \$5 if the employee did not voluntarily participate in the biometric screening initiative. Add \$5 if the employee did not voluntarily participate in the health risk assessment initiative.

Find out how the plans work and compare plans to determine which plan works best for you. Logon to www.mycignaplans.com between April 14, 2008 through June 30, 2009 using **username: Maricopa2008** and **password: cigna**

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

MEDICAL PLAN SUMMARY CHART

Benefit Provision	Open Access Plus High (OAP High):		Open Access Plus Low (OAP Low):		Choice Fund-HSA ¹ :	
Type of Plan	<u>HMO</u> with Open Access to Specialists		<u>HMO</u> with Open Access to Specialists		<u>High-deductible PPO</u> plan with partially funded Health Savings Account ¹ ; cant' be enrolled in any other type of medical insurance	
Service Area Where Care Must be Received	Nationally		Nationally		Nationally	
Residency Requirement	None		None		None	
PCP Required	No		No		No	
Referral Required	No		No		No	
Out-of-Network Coverage	Yes		Yes		Yes	
Network	National Open Access AZ300		National Open Access AZ300		National Preferred Provider Network AZ011	
Prior Authorization	Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.		Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.		Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.	
Per Pay Period (24/yr.) Medical Premiums**	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Employee	\$14.58	\$104.84	\$4.62	\$67.04	\$0.00	\$90.48
Employee + Spouse	\$64.30	\$117.44	\$17.76	\$74.26	\$0.00	\$105.30
Employee + Child(ren)	\$46.06	\$113.92	\$9.68	\$72.32	\$0.00	\$99.90
Employee + Family	\$95.42	\$123.44	\$30.46	\$76.72	\$0.00	\$114.24

**These premiums are based on all participants being tobacco free and employee voluntarily participating in the biometric screening and Health Risk Assessment initiatives. Medical premiums also include the behavioral health premium. Add \$15 per household for tobacco-users (employees and/or covered dependents). Add \$5 if the employee did not voluntarily participate in the biometric screening initiative. Add \$5 if the employee did not voluntarily participate in the health risk assessment initiative.

¹Maricopa County contributes \$500 for employee only or \$1,000 for employee and dependent coverage to your HSA pro-rated by the number of months remaining in the plan year. You can contribute up to \$2,400 (individual) or \$4,800 (family) to your HSA, plus \$900 catch-up if over 55. Unused balances rollover.

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MEDICAL COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		CIGNA Medical Group High (CMG High):	CIGNA Medical Group Low (CMG Low):	Open Access Plus In-Network (OAPIN):
		<i>In-Network Coverage Only</i>		
Deductible	Individual	None	None	None
	Family	None	None	None
Standard Percent of Co-insurance		N/A	90%	N/A
Out-of-Pocket Maximum	Individual	\$1,000	\$5,000	\$1,000
	Family	\$2,000	\$10,000	\$2,000
Pre-existing Condition Limitation		None	None	Yes, same as for OAP High & Low Options
Preventive Care		\$0 (FREE)	\$0 (FREE)	\$0 (FREE)
Primary Care Physician Services		\$15	\$25	\$20
Specialty Care Physician Services		\$25* / \$40	\$45* / \$60	\$30* / \$45
Advanced radiology: CT, PET, MRI, MRA Scans/type of scan/day and nuclear cardiac studies**		\$50	\$100	\$100
Allergy Injections		\$8* / \$23	\$13* / \$28	\$10* / \$25
Outpatient Lab and X-ray		\$0	\$0	\$0
Inpatient Facility Charges		\$100/admit	\$500/admit, then 10%	\$200/admit
Inpatient Physician and Surgeon's Services		\$0	\$0	\$0
Outpatient Facility Services		\$0	\$250, then 10%	\$100
Pre- & Postnatal Exams (after pregnancy has been determined)		\$25, waived after 1st visit	\$45, waived after 1st visit	\$30, waived after 1st visit
Delivery		\$100	\$500, then 10%	\$200
Urgent Care		\$35, waived if admitted	\$50, waived if admitted	\$50, waived if admitted
Emergency Room		\$125, waived if admitted	\$125, waived if admitted	\$125, waived if admitted
Ambulance		\$0	\$0	\$0
Durable Medical Equipment No annual limit		\$0	\$0	\$0
External Prosthetics		\$0	\$0	\$0
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy 120 visits maximum combined/yr.		\$25/provider/day***	\$45/provider/day***	\$30/provider/day
Cardiac Rehab; 36 visits/yr.		\$25 per visit	\$45 per visit	\$30 per visit
Alternative Medicine; 20 visits/yr. \$60 credit for supplies/products		\$15 per visit	\$25 per visit	\$20 per visit
Behavioral Health/Pharmacy		Magellan/WHI	Magellan/WHI	Magellan/WHI

For more detail, review the medical plan summaries on the EHI Home Page or go to www.mycignaplans.com to compare plans.

*CIGNA Care Network Specialist

**Advanced radiology copays apply in addition to inpatient, outpatient and emergency room copays or co-insurance.

***Chiropractic visits have a separate 60 visit limit per year. Other therapies have a combined 60 visit per year.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

MEDICAL COPAY/CO-INSURANCE COMPARISON CHART

Open Access Plus High (OAP High):		Open Access Plus Low (OAP Low):		Choice Fund-HSA:	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
None	\$500	None	\$1,000	\$1,200 (cross accumulated)	\$1,200 (cross accumulated)
None	\$1,000	None	\$2,000	\$2,400 (cross accumulated)	\$2,400 (cross accumulated)
N/A	70% of reasonable and customary	90%	70% of reasonable & customary	90%	70% of reasonable & customary
\$1,500	\$3,000	\$5,000	\$10,000	\$2,000 (cross accumulated)	\$2,000 (cross accumulated)
\$3,000	\$6,000	\$10,000	\$20,000	\$4,000 (cross accumulated)	\$4,000 (cross accumulated)
12 months for treatment in prior 60 days. Waived with certificate of creditable coverage and for employees currently covered by a county medical plan for at least 12 months. Certificate of creditable coverage must be sent to CIGNA and also provided to the EHI Department.					
\$0 (FREE)	Covered in-network only	\$0 (FREE)	Covered in-network only	\$0 (FREE)	Covered in-network only
\$25	30% after deductible	\$35	30% after deductible	10% after deductible	30% after deductible
\$35* / \$50	30% after deductible	\$50* / \$65	30% after deductible	10% after deductible	30% after deductible
\$100	30% after deductible	10%	30% after deductible	10% after deductible	30% after deductible
\$13* / \$28	30% after deductible	\$18* / \$33	30% after deductible	10% after deductible	30% after deductible
\$0	30% after deductible	10%	30% after deductible	10% after deductible; \$0, no deductible if preventative	30% after deductible
\$250/admit	30% after deductible	\$1,000/admit, then 10%	\$2,000/admit, then 30%	10% after deductible	30% after deductible
\$0	30% after deductible	10%	30% after deductible	10% after deductible	30% after deductible
\$100	30% after deductible	\$500, then 10%	\$1,000/admit, then 30% after deductible	10% after deductible	30% after deductible
\$35, waived after 1st visit	30% after deductible	\$50, then 10%	30% after deductible	10% after deductible	30% after deductible
\$250	30% after deductible	\$1,000, then 10%	\$2,000, then 30% after deductible	10% after deductible	30% after deductible
\$50, waived if admitted	\$50, waived if admitted	\$75, waived if admitted	\$75, waived if admitted	10% after deductible	10% after deductible
\$125, waived if admitted	\$125, waived if admitted	\$150, waived if admitted	\$150, waived if admitted	10% after deductible	10% after deductible
\$0	\$0	10%	10%	10% after deductible	10% after deductible
\$0	30% after deductible	10%	30% after deductible	10% after deductible; No limit	30% after deductible; No limit
\$0	30% after deductible	10%	30% after deductible	10%	30% after deductible
\$35/provider/day	30% after deductible/ provider/day	\$50/provider/day	30% after deductible/ provider/day	10% after deductible/ provider/day	30% after deductible/ provider/day
\$35 per visit	30% after deductible	\$35 per visit	30% after deductible	10% after deductible	30% after deductible
\$25 per visit	Covered in-network only	\$35 per visit	Covered in-network only	\$15 per visit	Covered in-network only
Magellan/WHI	Magellan/WHI	Magellan/WHI	Magellan/WHI	CIGNA Behavioral Health/CIGNA Pharmacy	

For more detail, review the medical plan summaries on the EHI Home Page or go to www.mycignaplans.com to compare plans.

*CIGNA Care Network Specialist

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.



PHARMACY PLANS

Administered by Walgreens Health Initiatives (WHI)

If you enroll in a medical plan, except for the Choice Fund HSA plan, you must enroll in one of the pharmacy plans below. However, you may not enroll your dependents in a pharmacy plan if they are not enrolled in your medical plan.

Co-insurance Benefit Plan

The Co-insurance benefit is a five-level plan in which a co-insurance amount (percentage of the cost¹ of the medication) is charged (unless the applicable minimum or maximum copay applies) based on the classification of the medication. This plan covers generic, preferred brand-name, non-preferred brand-name and specialty medication. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility and cosmetic medications, are excluded. You are responsible for paying 100% of the contracted cost for excluded medications.

You will be charged the minimum or maximum copay or the co-insurance amount for the medication, based on the medication's level and cost. If you choose a non-preferred brand-name medication when a generic equivalent is available, you will also pay the difference in the cost between the medications.

The co-insurance or the minimum or maximum copay you pay toward any covered medication apply to your out-of-pocket maximum except when a non-preferred brand name medication with a generic equivalent is purchased, the difference between the brand and the generic equivalent will not count. The out-of-pocket limit is \$1,500 for an individual and \$3,000 for a family². Once the out-of-pocket limit is met, covered medications are paid 100% by the plan for the remainder of the plan year, except for the difference between the non-preferred brand and its generic equivalent, which will continue to be your responsibility.

Annual Out-of-Pocket Maximum \$1,500 Single / \$3,000 Family ²				
	Classification	Up to 30-Day Supply		
Level 1	Generic	\$2 Minimum	25% Co-insurance ¹	\$12 Maximum ³
Level 2	Preferred Brand	\$5 Minimum	30% Co-insurance ¹	\$30 Maximum ³
Level 3	Non-Preferred Brand with Generic equivalent	\$20 Minimum	50% Co-insurance ¹ +	Difference between brand & generic cost
Level 4	Non-Preferred Brand with No Generic equivalent	\$20 Minimum	50% Co-insurance ¹	
Level 5	Non-Preferred Brand Specialty Drugs	\$50 Copay		

Per Pay Period (24/yr.) Pharmacy Premiums	Full-Time	Part-Time
Employee	\$5.16	\$14.26
Employee+Spouse	\$10.22	\$20.26
Employee+Child(ren)	\$7.68	\$17.48
Employee+Family	\$15.34	\$25.78

¹ Cost of medication is calculated by average wholesale price - discount or maximum allowable cost + dispensing fee. Discount amount varies by place of service and number of days supplied. To find the lowest cost for medication between retail, Advantage90™ and mail service, go to www.mywhi.com

² Family refers to employee and one or more covered dependents.

³ Maximums are reduced when mail service is used.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

Contact Walgreens Health Initiatives for additional information, or view the detailed [Pharmacy Summary Plan](#) document available on the Intranet EHI site at ebc.maricopa.gov/ehi.

Consumer Choice Benefit Plan

The Consumer Choice Plan has four levels of coverage:

- Level 1 is a County funded pharmacy account. The County will place \$300 in an Individual account or \$500 in a Family account (family in this case is defined as more than 1 person covered). In terms of Family coverage, the \$500 is available to whichever family members use the pharmacy benefit on a first come, first served basis and no one individual on a Family plan may exceed \$300 of the allocated \$500.
- Level 2 consists of the Employee deductible portion and begins when the \$300 Individual or \$500 Family amount in Level 1 is exhausted. Employees must then meet their deductible of \$300 for an Individual or \$500 for a Family before moving to the next level. Individuals insured under a Family plan who reach \$300 of the \$500 deductible are able to move to the Level 3 benefit while the rest of the family must remain at Level 2 until the additional \$200 is met.
- Level 3 is more like your traditional insurance coverage where the County pays 80% of the cost of the medication and you pay 20% of the cost for the remainder of the benefit year.
- Level 4 is limited to specialty medications only and consists of a \$50 copayment. Specialty medication copayments are not charged against any of the first 3 levels.

For further clarification on the Consumer Choice Pharmacy Plan, please refer to the Pharmacy Benefit Plan booklet found on the EHI Home page.

The Consumer Choice benefit is geared towards smart spending through the use of the most cost-effective medication. A preferred medication list (PML) is not used to manage this benefit because much of the management is up to you. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility, cosmetics, smoking cessation and non-steroid anti-inflammatory medications are excluded.

The amounts you pay toward any covered medication will apply to your plan year out-of-pocket maximum. The out-of-pocket maximum is \$1,500 for individual coverage or \$3,000 for family² coverage. Once the out-of-pocket maximum is met, covered prescriptions are paid 100% by the plan for the remainder of the plan year.

Annual Out-of-Pocket Maximum \$1,500 Single / \$3,000 Family ²					
<i>Certain generic preventive medications are provided at no cost. List available on the EHI Home Page.</i>					
Level 1	Pharmacy Account	Individual Family ²	\$300 Individual \$500 Family	100% Employer paid ¹	Any unused amount is carried over to next plan year
Level 2	Employee Responsibility	Individual Family ²	\$300 Individual \$500 Family	100% Employee paid ¹	
Level 3	Traditional Insurance Coverage			20% ¹ covered by Employee	80% ¹ covered by Employer
Level 4	Specialty Drug	\$50 copay; does not apply to pharmacy account, employee responsibility or insurance levels; Copay applies to out-of-pocket maximum.			

Per Pay Period (24/yr.) Pharmacy Premiums	Full-Time	Part-Time
Employee	\$0.00	\$9.10
Employee+Spouse	\$0.00	\$10.02
Employee+Child(ren)	\$0.00	\$9.80
Employee+Family	\$0.00	\$10.42

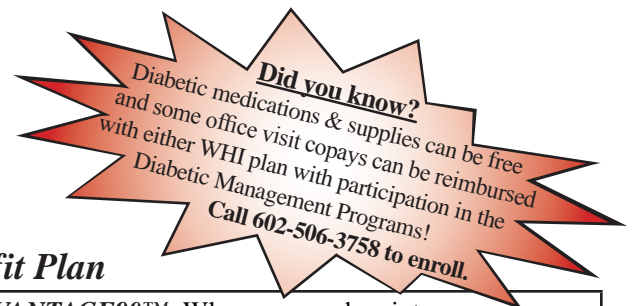
¹ Cost of medication is calculated by average wholesale price - discount or maximum allowable cost + dispensing fee. Discount amount varies by place of service and number of days supplied. To find the lowest cost for medication between retail, Advantage90™ and mail service, go to www.mywhi.com

² Family refers to employee and one or more covered dependents.

³ Maximums are reduced when mail service is used.

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Contact Walgreens Health Initiatives for additional information, or view the detailed [Pharmacy Summary Plan](#) document available on the Intranet EHI site at ebc.maricopa.gov/ehi.



Co-insurance Benefit Plan & Consumer Choice Benefit Plan

THREE-MONTH SUPPLY AT CERTAIN RETAIL PHARMACIES – ADVANTAGE90™ When you need maintenance medications for chronic or long-term health conditions, you must purchase a three-month supply at any pharmacy located in a retail pharmacy participating in Advantage90™ or through mail service, after two fills of 30 or less days supply of a maintenance medication at a retail pharmacy. The physician must write your prescription for an 84-91 day supply. Refer to www.mywhi.com for a list of pharmacies participating in Advantage90™. Your cost for a three-month supply at an Advantage90™ retail pharmacy is may be slightly less than three times the one-month supply copay or co-insurance.

THREE-MONTH SUPPLY THROUGH THE MAIL SERVICE PHARMACY Prescriptions for maintenance medications or long-term health conditions can be ordered through the Walgreens Mail Service pharmacy. Besides being convenient, you could save more money! Maximum copayments and co-insurance for the Co-insurance plan are reduced when mail service is used. Level One (generic) has 15% co-insurance with a maximum of \$28, and Level Two (preferred brand) has 25% co-insurance with a maximum of \$70. For the Consumer Choice Plan, you may save money as many of the medications, especially generics, have a higher discounted contracted cost than medications filled at a retail or Advantage90™ pharmacy. You must use a specific order form when placing your first order so as to provide Walgreens Mail Service with important health, allergy and plan information. This form is called the Tempe Registration and Order Form and is available online at the EHI Home Page or at www.mywhi.com.

If purchasing medication in a three-month supply is financially problematic, please consider enrolling in either the Choice Fund HSA medical plan that uses the CIGNA pharmacy plan and does not require you to purchase maintenance medication in three-month quantities, or enrolling in the Health Care FSA (Flex Spending Health Care) and requesting a debit card (requires an additional fee of \$0.75 per pay period). The debit card allows you to pay for your medication in advance up to your annual pre-tax Flexible Spending Account contribution in advance of collecting your full annual contribution. Contact ASI for specific details.

Note: Diabetic supplies and medications may be obtained at a CIGNA Medical Group pharmacy for \$10 per item for a 30-day supply. Please show your CIGNA ID card since these costs will be charged to your medical plan instead of your pharmacy plan.

You and/or your covered dependents may voluntarily enroll in the Maricopa County Diabetic Management Program to qualify for free diabetic medications and supplies if you have elected either the Co-insurance or Consumer Choice plan. Once you or your dependents meet the 9 required measures, not only are you able to receive all diabetic medications and supplies free of charge, you also will be eligible to enroll in the Healthy Living Diabetes Care Management Program. Upon completion of this educational program, you will be reimbursed for up to 9 diabetic-related office visit copays per plan year. For information regarding these programs or to request enrollment, please call (602) 506-3758.

CIGNA Pharmacy Plan for Choice Fund HSA Plan

If you enrolled in the Choice Fund HSA Medical plan, your pharmacy benefit is provided through CIGNA instead of WHI. The CIGNA plan consists of a three-level co-insurance plan.

CIGNA Pharmacy Plan for Choice Fund HSA Plan

Level 1	Generic	30% after deductible
Level 2	Preferred Brand	40% after deductible
Level 3	Non-Preferred Brand	50% after deductible
Certain generic and preferred brand preventive medications are provided at no cost (Deductible does not apply to these preventive medications).		

Cost of pharmacy plan included in medical premium for Choice Fund HSA plan
Refer to www.cigna.com for a list of medications by level.

The pharmacy benefit for Choice Fund HSA is administered by:



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Contact Walgreens Health Initiatives for additional information, or view the detailed [Pharmacy Summary Plan](#) document available on the Intranet EHI site at ebc.maricopa.gov/ehi.

COMBINED RATE SHEET

Per Pay Period Total Medical Rates for Non-Tobacco Users and
Employees Participating in the Biometric Screening and Health Risk Assessment
(Includes Medical, pharmacy, behavioral health, vision)

Add \$15 per household for tobacco-users (employees and/or covered dependents)

Add \$5 if the employee did not voluntarily participate in the biometric screening initiative

Add \$5 if the employee did not voluntarily participate in the health risk assessment initiative

CMG High option + Co-insurance Rx	Full-time	Part-time
Employee	\$11.08	\$99.64
Employee + Spouse	\$32.36	\$115.54
Employee + Child(ren)	\$19.84	\$109.86
Employee + Family	\$53.58	\$125.20

CMG High

CMG High option + Consumer Choice Rx	Full-time	Part-time
Employee	\$5.92	\$94.48
Employee + Spouse	\$22.14	\$105.30
Employee + Child(ren)	\$12.16	\$102.18
Employee + Family	\$38.24	\$109.84

CMG Low option + Co-insurance Rx	Full-time	Part-time
Employee	\$9.50	\$74.54
Employee + Spouse	\$27.34	\$91.66
Employee + Child(ren)	\$17.04	\$86.40
Employee + Family	\$44.50	\$99.14

CMG Low

CMG Low option + Consumer Choice Rx	Full-time	Part-time
Employee	\$4.34	\$69.38
Employee + Spouse	\$17.12	\$81.42
Employee + Child(ren)	\$9.36	\$78.72
Employee + Family	\$29.16	\$83.78

OAP In-Network + Co-insurance Rx	Full-time	Part-time
Employee	\$17.12	\$101.20
Employee + Spouse	\$65.34	\$117.00
Employee + Child(ren)	\$47.02	\$111.58
Employee + Family	\$97.04	\$126.74

OAPIN

OAP In-Network + Consumer Choice Rx	Full-time	Part-time
Employee	\$11.96	\$96.04
Employee + Spouse	\$55.12	\$106.76
Employee + Child(ren)	\$39.34	\$103.90
Employee + Family	\$81.70	\$111.38

OAP High option + Co-insurance Rx	Full-time	Part-time
Employee	\$19.74	\$119.10
Employee + Spouse	\$74.52	\$137.70
Employee + Child(ren)	\$53.74	\$131.40
Employee + Family	\$110.76	\$149.22

OAP High

OAP High option + Consumer Choice Rx	Full-time	Part-time
Employee	\$14.58	\$113.94
Employee + Spouse	\$64.30	\$127.46
Employee + Child(ren)	\$46.06	\$123.72
Employee + Family	\$95.42	\$133.86

OAP Low option + Co-insurance Rx	Full-time	Part-time
Employee	\$9.78	\$81.30
Employee + Spouse	\$27.98	\$94.52
Employee + Child(ren)	\$17.36	\$89.80
Employee + Family	\$45.80	\$102.50

OAP Low

OAP Low option + Consumer Choice Rx	Full-time	Part-time
Employee	\$4.62	\$76.14
Employee + Spouse	\$17.76	\$84.28
Employee + Child(ren)	\$9.68	\$82.12
Employee + Family	\$30.46	\$87.14

Choice Fund HSA + CIGNA Rx	Full-time	Part-time
Employee	\$0.00	\$90.48
Employee + Spouse	\$0.00	\$105.30
Employee + Child(ren)	\$0.00	\$99.90
Employee + Family	\$0.00	\$114.24

Choice Fund HSA



DENTAL PLAN SUMMARY CHART

Benefit Provision	EDS		CIGNA Dental*		Delta Dental**	
Type of Plan	<u>DCO</u> (Dental Care Organization)		<u>PPO</u>		<u>PPO</u> (but does not use PPO network; see network below.)	
Service Area Where Care Must be Received	Maricopa County		Nationally		Nationally	
Residency Requirement	No		No		No	
Primary Care Dentist Required	Yes, all family members must choose the same dentist		No		No	
Referral Required	No		No		No	
Out-of-Network Coverage	No		Yes		Yes	
Network	EDS Provider Network		CIGNA Dental Network		Delta Premier Network	
Prior Authorization	No		No, predetermination recommended for services over \$250		No, predetermination recommended for services over \$250	
Location of Provider Directory	<u>www.mydentalplan.net</u>		<u>www.cigna.com</u>		<u>www.deltadentalaz.com</u>	
Per Pay Period (24/yr.) Dental Premiums						
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Employee	\$2.16	\$2.16	\$6.98	\$11.58	\$11.18	\$15.78
Employee + Spouse	\$4.10	\$4.10	\$15.38	\$26.44	\$24.66	\$35.72
Employee + Child(ren)	\$5.38	\$5.38	\$16.64	\$27.32	\$26.66	\$37.34
Employee + Family	\$6.18	\$6.18	\$21.36	\$36.10	\$34.24	\$49.00

*Includes the CIGNA Dental Oral Health Integration Program® that addresses risks to pregnancy, diabetes and cardiovascular disease through improved oral health; includes enhanced dental benefits for pregnant members and members enrolled in disease management programs for diabetes and heart disease; also includes coverage for brush biopsy to screen for oral cancer.

**Includes a third dental cleaning for women in their third trimester of pregnancy or members with diabetes.

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DENTAL COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		EDS*	CIGNA Dental***		Delta Dental	
		In-Network coverage only	In and Out-of-Network coverage			
Deductible	Individual	\$0	\$50		\$50	
	Family	\$0	\$100		\$100	
Annual Individual	Standard	None	\$2,000		\$2,000	
Benefit Maximum	Orthodontic	None	\$3,000		\$3,000	
Pre-existing Condition Limitation		Procedures in progress at time of enrollment are not covered	5 year waiting period for replacement (major services)		5 year waiting period for replacement (major services)	
Class I - Preventive Care Services			Amount Paid by the Member			
Preventive Care		\$0 \$12/tooth \$20 + lab fees	In-Network	Out-of-Network**	In-Network	Out-of-Network**
Routine Cleanings			Deductible waived			
Sealants			\$0	20%	\$0	\$0
Space Maintainers						
Diagnostic		Copay \$0-\$20	Deductible waived			
Exams			\$0	20%	\$0	\$0
Evaluations						
Consultations & X-rays						
Emergency		Up to \$200 reimbursement less applicable copay	Deductible waived			
Palliative Treatment			\$0	20%	\$0	\$0
Treatment for the relief of pain						
Class II - Basic Restorative Services			Amount Paid by the Member			
Restorative		Amalgam \$8-\$21 Resin \$22-\$40	Amalgam 20%	Amalgam 40%	Amalgam 20%	Amalgam 20%
Fillings			Resin 50%	Resin 50%	Resin 50%	Resin 50%
Oral Surgery		From \$35	20%	40%	20%	20%
Extractions						
Endodontics		Copay \$170-\$265	20%	40%	20%	20%
Root Canal Treatment						
Pulpotomy						
Periodontics		Debridement: \$80 Root Planing: \$90	20%	40%	20%	20%
Treatment of gum disease						
Periodontal Maintenance						
Bridge & Denture Repair		\$10 + lab fees	20%	40%	20%	20%
Class III - Major Restorative Services			Amount Paid by the Member			
Prosthodontics		\$250 + lab fees \$375 + lab fees \$325 + lab fees	50%		50%	
Bridges per pontic						
Partial Dentures						
Complete Dentures (upper or lower)						
Restorative		\$250 + lab fees \$135 - \$170	50%		50%	
Cast Crowns & Jackets						
Onlays & Inlays						
Class IV - Orthodontic Services			Amount Paid by the Member			
Orthodontic maximum is separate from annual benefit maximum		25% discount children & adults	50% children & adults		50% Adults & children age 8 + older	

*Specialist Care & treatment of TMJ are offered at a discount.

**If the dentist charges more than the reasonable & customary allowance, you will be liable for the difference between the allowance and the billed amount in addition to the applicable deductible and co-insurance.

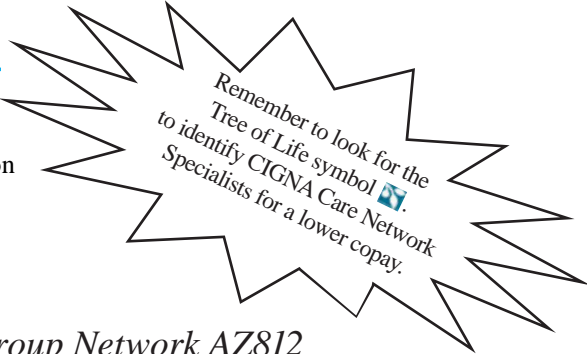
*** Progressive/Regressive Base Plan. If you enroll in this plan, if you receive a preventive service during FY 08-09 plan year you increase your level of coverage for the next plan year.

For more detail, review the dental plan documents on the EHI Home Page.

HOW TO LOOK UP A PHYSICIAN OR DENTIST ONLINE

CIGNA Medical and Dental Plans – Start at www.cigna.com

1. From the home page, select the Provider Directory link (at top of screen)
2. For medical, enter your physician search information
For dental, select the radio button next to Dentist and enter the search information
3. Click on the “Next” button
4. Continue with the applicable instructions below



Remember to look for the Tree of Life symbol  to identify CIGNA Care Network Specialists for a lower copay.

CMG High and Low Options use the AZ – CIGNA Medical Group Network AZ812

1. On the next page, under “What type of plan you have” section, choose “Network (HMO) Plans or Point of Service (POS) Plans”
2. From the “Network (HMO) Plans or Point of Service (POS) Plans” drop-down list, select AZ-CIGNA Medical Group
3. Under “What you’re looking for” section, select “Primary Care Physician” or “Specialist” and the type from the corresponding drop-down list
4. Click on the “Search” button to view the provider search response

OAP In-Network and OAP High and Low Options use the National Open Access Plus Network AZ300

1. On the next page, under the “What type of plan you have” section, choose “Open Access Plus Only”
2. Under “What you’re looking for” section, select “Primary Care Physician” or “Specialist” and the type from the corresponding drop-down list
3. Click on the “Search” button to view the provider search response

Choice Fund Health Savings Account (HSA) use the National Preferred Provider Network AZ011

1. On the next page, under “What type of plan you have” section, choose “Preferred Provider Organizations (PPO)”
2. Under “What you’re looking for” section, select a physician listed under the “Specialist” area and the type from the corresponding drop-down list
3. Click on the “Search” button to view the provider search response

CIGNA Dental

On the next page, under “What type of plan you have” section, choose “Managed care plan with open access to dentists for CIGNA Dental PPO” and the type from the drop-down list. Click on the “Search” button to view the dental search response.

Other Dental Plans

EDS

1. Start at www.mydentalplan.net
2. From the Home page, under the Members Tool section, click on the “Dentist Search” link
3. You can search by city, dentist’s last name or download a provider directory

Delta Dental

1. Start at www.deltadentalaz.com
2. Click on Dentist and then Dentist Search
3. When a new page appears, under “1. Product Selection”, select “Dental Premier” and continue entering the identifying information
4. Or call 602-938-3131 and select 5 and enter the zip code to hear a listing of dentists in your area

VISION PLAN

Administered by EyeMed Vision Care

If you enroll in any County medical plan, you must enroll (cannot waive) in the vision benefit. The County also offers this plan as a separate (stand-alone) vision plan for employees who choose to waive their medical benefits and wish to enroll in the vision plan.

However, you may not enroll your dependents in a vision plan if they are not enrolled in your medical plan.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	\$10 Copay	\$35
Exam Options: Standard Contact Lens Fit and Follow-Up* Premium Contact Lens Fit and Follow-Up**	Up to \$55 10% off retail price	N/A N/A
Frames: Any available frame at provider location	\$130 allowance, 20% off balance over \$130	\$50
Standard Plastic Lenses: Single Vision Bifocal Trifocal Lenticular	\$10 Copay \$10 Copay \$10 Copay \$10 Copay	\$25 \$40 \$55 \$55
Lens Options: UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (Add-on to Bifocal) Other Add-ons and Services	\$15 \$15 \$15 \$0 \$45 \$65 20% off retail price	N/A N/A N/A \$25 N/A N/A N/A
Contact Lenses: (Contact lens allowance covers materials only) Conventional Disposable Medically Necessary	\$0 Copay, \$130 allowance, 15% off balance over \$130 \$0 Copay, \$130 allowance, plus balance over \$130 \$0 Copay, Paid-in-Full	\$130 \$130 \$250
Laser Vision Correction	\$150 allowance; once per lifetime per eye	N/A
Frequency: Examination Frame Lenses or Contact Lenses	Once every 12 months Once every 12 months Once every 12 months	

*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement
(Examples include but not limited to disposable, frequent replacement, etc.)

**Premium Contact Lens Fitting - all lens designs, materials and speciality fittings other than Standard Contact Lenses
(Examples include toric, multifocal, etc.)

Additional Discounts:

Member will receive a 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location. Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance. Lost or broken materials are not covered. Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA vision.

Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-5LASER6.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Per Pay Period (24/yr.) Vision Premiums w/Medical Plan

	Full-time	Part-time
Employee	\$0.00	\$0.00
Employee + Spouse	\$0.00	\$0.00
Employee + Child	\$0.00	\$0.00
Employee - Family	\$0.00	\$0.00

Per Pay Period (24/yr.) Vision Premiums w/o Medical Plan

	Full & Part-time
Employee	\$4.84
Employee + Spouse	\$9.12
Employee + Child	\$9.56
Employee - Family	\$14.04

Basic Life and Basic AD&D - Employee Only Coverage

Maricopa County provides all benefit-eligible employees with the following benefits paid in full by Maricopa County:

- Basic term life insurance coverage equal to their annual salary to a maximum of \$500,000
- Accidental Death coverage equal to their basic term life insurance coverage, if an accident is the cause of death
- Accidental Dismemberment coverage as a percentage of the basic term life insurance coverage

All benefit-eligible employees have the option to purchase the following benefits paid in full by the employee:

Additional Life Insurance - Employee Only Coverage

Additional life coverage amounts are available in 1, 2, 3, 4, or 5 times the employee's annual salary. The total amount of Basic Life and Additional Life may not exceed \$1,000,000. During Open Enrollment the Additional Life coverage may be increased by one level without providing evidence of insurability up to the guarantee issue limit of \$500,000. Evidence of insurability is required for coverage amounts greater than \$500,000.

The premium for Additional Life coverage is based on your smoker status and your age as of January 1 of the current year.

Spouse Life Insurance Coverage

Spouse Life coverage may be purchased for the employee's legal spouse in increments of \$10,000, from \$10,000 to a maximum of \$100,000. The spouse coverage amount may not exceed the total amount of the employee's life insurance (Basic and Additional combined). Evidence of insurability is required for spouse coverage amounts greater than \$50,000.

The premium for Spouse Life Insurance coverage is based on the age of the spouse as of January 1 of the current year.

If the employee's spouse is currently insured for \$5,000 and the employee does not make an election during the open enrollment period immediately preceding July 1, 2008, the Spouse Life Insurance benefit will automatically increase to \$10,000 on July 1, 2008.

Child Life Insurance Coverage

Child Life coverage may be purchased for the employee's dependent child(ren) from live birth to age 19, or to age 25 if a full-time student. Coverage may also be purchased for a continuously disabled child(ren). You must provide proof of disability to The Standard within 31 days after a) the date insurance would otherwise end because of the child's age or b) the effective date of Maricopa County's coverage under Standard's policy, if your child is disabled on that date.

Coverage is available in increments of \$5,000, from \$5,000 to a maximum of \$20,000. The child coverage amount may not exceed the total amount of the employee's life insurance (Basic and Additional combined). Evidence of insurability is required for child coverage amounts greater than \$10,000.

If the employee's child(ren) is currently insured for \$2,500 and the employee does not make an election during the open enrollment period immediately preceding July 1, 2008, the Child Life Insurance benefit will automatically increase to \$5,000 on July 1, 2008.

Additional AD&D Insurance - Employee Only Coverage

Additional AD&D coverage is available in increments of 1, 2, 3, 4, or 5 times the employee's annual salary, to a maximum of \$500,000. This coverage may be purchased separately from or in addition to Employee Only Additional Life Insurance. This coverage may not be purchased in combination with Family Additional AD&D Insurance.

Additional AD&D - Family Coverage

Additional AD&D coverage is available for the employee, and his or her legal spouse and dependent child(ren).

This coverage is available in increments of 1, 2, 3, 4, or 5 times the employee's annual salary to a maximum of \$500,000 for the employee.

For other dependents, the coverage amount is a) 60% of employee's additional AD&D coverage when only a spouse is covered; b) 10% of employee's additional AD&D coverage when only a child(ren) is covered up to \$25,000 maximum; and c) 50% of employee's additional AD&D coverage for a spouse and 5% for each child when both spouse and child(ren) are covered.

This coverage may not be purchased in combination with Employee Only Additional AD&D insurance.

How to complete your Evidence of Insurability

Evidence of insurability (Medical History Statement) may be required when you make your election for additional life insurance depending on the level requested and the total value of your basic and additional life insurance. Should you need to fill out a Medical History Statement, you must complete and submit your benefit package elections first. Then submit your Medical History Statement, either online via The Standard's website, or directly to the Employee Health Initiatives Department. The Medical History Statement form is available at www.standard.com/mybenefits/maricopa or http://ebc.maricopa.gov/ehi/pdf/2008/standard/medical_history_statement.pdf.

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LIFE INSURANCE

Additional Life and/or Accidental Death and Dismemberment (AD&D)
1 to 5 times Base Salary - 100% Paid by Employee

Additional Life Insurance Table - Employee Only

5 Year Age Categories (Age on last January 1)	Employee Cost Monthly per \$1,000 of Coverage (Non-Smoker Multiplier)	Employee Cost Monthly per \$1,000 of Coverage (Smoker Multiplier)
Under 25	\$0.040	\$0.065
25-29	\$0.047	\$0.070
30-34	\$0.062	\$0.080
35-39	\$0.070	\$0.136
40-44	\$0.092	\$0.194
45-49	\$0.150	\$0.385
50-54	\$0.230	\$0.709
55-59	\$0.390	\$0.722
60-64	\$0.660	\$1.120
65-69	\$0.950	\$1.370
70 and older	\$1.760	\$2.250

Additional Life Insurance Premium Calculator Example

Take your annual base salary - example: \$24,500					
Round up to the nearest \$1,000	\$25,000	\$25,000	\$25,000	\$25,000	\$25,000
Multiply	1x Salary	2x Salary	3x Salary	4x Salary	5x Salary
Salary amount ÷ divided by \$1,000	\$25,000	\$50,000	\$75,000	\$100,000	\$125,000
	25	50	75	100	125

Refer to the Additional Life Insurance table above to find your age category and multiplier

Multiply the divided result from the last calculation in the table above by the multiplier and divide by 2 to calculate the per pay period premium

Example: Age 37	Multiplier for Non-Smoking \$0.070	Multiplier for Smoking \$0.136	Coverage Amount
1 x Salary	$\$0.070 \times 25 = \$1.75/2 = \mathbf{\$0.88}$	$\$0.136 \times 25 = \$3.40/2 = \mathbf{\$1.70}$	\$25,000
2 x Salary	$\$0.070 \times 50 = \$3.50/2 = \mathbf{\$1.75}$	$\$0.136 \times 50 = \$6.80/2 = \mathbf{\$3.40}$	\$50,000
3 x Salary	$\$0.070 \times 75 = \$5.25/2 = \mathbf{\$2.63}$	$\$0.136 \times 75 = \$10.20/2 = \mathbf{\$5.10}$	\$75,000
4 x Salary	$\$0.070 \times 100 = \$7.00/2 = \mathbf{\$3.50}$	$\$0.136 \times 100 = \$13.60/2 = \mathbf{\$6.80}$	\$100,000
5 x Salary	$\$0.070 \times 125 = \$8.75/2 = \mathbf{\$4.38}$	$\$0.136 \times 125 = \$17.00/2 = \mathbf{\$8.50}$	\$125,000

Dependent Life and Additional AD&D Insurance Tables

100% paid by Employee

Age on last January 1	Monthly for Spouse
Under 25	\$0.06/\$1,000
25-29	\$0.07/\$1,000
30-34	\$0.08/\$1,000
35-39	\$0.10/\$1,000
40-44	\$0.12/\$1,000
45-49	\$0.20/\$1,000
50-54	\$0.34/\$1,000
55-59	\$0.54/\$1,000
60-64	\$0.90/\$1,000
65-69	\$1.28/\$1,000
70 and older	\$2.08/\$1,000

Children (live birth to 25 years if full-time student)	
Cost Per Pay Period	Coverage Amount
\$0.25	\$5,000
\$0.50	\$10,000
\$0.75	\$15,000
\$1.00	\$20,000

Monthly for Family AD&D
\$0.035 per \$1,000
Employee Only AD&D
\$0.02 per \$1,000

This information is only a brief description of the group Basic Life/AD&D, Additional Life/AD&D insurance policy. For more complete details of coverage, contact The Standard.

MARIFLEX FLEXIBLE SPENDING ACCOUNTS

Maricopa County offers two flexible spending accounts (FSA) that allow you to pay for health care and/or day care expenses for your dependents with tax-free money. You must enroll during each Open Enrollment to renew your spending account(s). This Open Enrollment you are enrolling in flexible spending account(s) effective for expenses incurred from July 1, 2008 through June 30, 2009 or in the 2 ½ month grace period (July 1 - Sept. 15, 2009). Money that is put in an FSA will be forfeited if claims are not incurred within this 14½ month period.

When you elect to participate in an FSA, your gross income is reduced because your FSA contributions are not subject to Medicare, OASDI, federal or state income taxes. Since your benefit plan year is based on the fiscal year you will be responsible for controlling your IRS mandated calendar year maximum.

If purchasing medication in a 3-month supply is financially problematic, please consider either enrolling in the Choice Fund Health Savings Account medical plan that has a CIGNA pharmacy plan that does not require purchasing medication in 3-month quantities, or enrolling in the Health Care Flexible Spending Account (Flex Spending Health Care) and requesting a debit card (requires an additional fee of \$0.75 per pay period). The debit card allows you to pay for your medication up to your annual pre-tax Flexible Spending Account contribution in advance of collecting your full annual contribution. Contact ASI at www.asiflex.com or call 800-659-3035 for specific details.

HEALTH CARE FSA

You can enroll in the health care FSA (unless you enroll in the Choice Fund HSA medical plan or are covered by another HSA) to pay for eligible health care expenses that are not covered by your insurance such as office visit or prescription copays. Certain over-the-counter products purchased to treat an existing or imminent medical condition may qualify as a covered medical expense. These over-the-counter items include allergy medications, smoking cessation products, aspirin, and cold medications. Eligible expenses are defined by the Internal Revenue Service and can be found in IRS Publication 502.

You can set aside up to \$5,200 as your plan year contribution.

An optional debit card is available for a small monthly payroll deduction. The debit card will allow you to process your claim at the time you receive your service.

Because the Walgreens Health Initiatives pharmacy plans require you to purchase maintenance medication in 90-day quantities, it can be very beneficial for you to consider opening an FSA since your plan year contribution is available as of July 1.

LIMITED USE FSA

If you enroll in the CIGNA Choice Fund HSA medical plan, you can still take advantage of the Mariflex plan. However, you and your covered dependents can only participate in the Limited Use plan. This plan allows you to be reimbursed for dental and vision care services (as defined by the IRS).

You can set aside up to \$5,200 as your plan year contribution.

DEPENDENT DAY CARE FSA

Dependent care Flexible spending accounts allow you to use pre-tax money to pay for dependent daycare for your dependents under 13 or your spouse or dependent who is physically or mentally incapable of self-care which gives you and your spouse the ability to work. Refer to IRS publication 503 for more information.

You can set aside up to \$5,000 as your calendar year maximum contribution.

To find out more about the Mariflex FSAs including what items are eligible for reimbursement, contact ASI, the Mariflex Flexible Spending Account Administrator by phone or via email with your specific questions.



WHAT IS SHORT-TERM DISABILITY (STD)?

Short-term disability (STD) is a plan that replaces a portion of your monthly salary while you are disabled. There is a 3-week waiting period and all FML/sick leave must be exhausted before benefits begin. The maximum payment period is 23 weeks. Any FML/sick leave that continues past the 3-week waiting period reduces the 23 week payment period.

What benefit coverage amount can you elect?

You elect the benefit coverage amount when you enroll for STD coverage. You may elect 40%, 50%, 60% or 70% of earnings. The maximum benefit is \$1,000 per week.

Note: If your weekly disability payment will be at the \$1,000 per week maximum, you may be enrolling in a coverage level with a higher multiplier than necessary. Refer to the STD calculator on the Benefits home page to determine the most cost-effective coverage level.

You may only increase or decrease your coverage during Open Enrollment. No changes will be allowed during the plan year (July 1 through June 30) except if the employee is activated for military duty.

This plan contains a pre-existing condition if you have a condition related to your disability for which you received treatment 90 days before your coverage became effective. In this case, benefits will not be payable for that condition until you have been treatment free for 3 months or covered by the plan for 12 months.

Changes resulting in an increase in benefits are subject to the pre-existing condition. Example: If you previously elected a 50% benefit and during an Open Enrollment period changed your election to a 70% benefit, the difference between the 50% and the 70% benefit is subject to pre-existing condition criteria.

How is your benefit payment calculated?

To calculate the amount of your weekly benefit, multiply your weekly earnings by the percentage of the benefit coverage amount you elected and deduct any other income you are receiving that offsets your benefit.

Benefits payable for less than one weekly period will be paid to you at the rate of one-seventh of the STD benefit amount for each day of disability.

Short-Term Disability Rate Calculation Example

Coverage	Multiplier
40%	0.38%
50%	0.55%
60%	0.85%
70%	1.32%

Annual Salary:	\$25,000
Annual Salary divided by 12 months = Monthly Salary	$\$25,000 \div 12 = \$2,083.33$

Monthly Salary: \$2,083.33	40% Option	50% Option	60% Option	70% Option
Monthly Premium = Monthly Salary (up to Maximum Monthly Salary) multiplied by Rate Multiplier	$\$2,083.33 \times 0.0038$	$\$2,083.33 \times 0.0055$	$\$2,083.33 \times 0.0085$	$\$2,083.33 \times 0.0132$
Monthly Premium	\$7.92	\$11.46	\$17.71	\$27.50
Pay Period Premium = Monthly Premium divided by 2	\$3.96	\$5.73	\$8.86	\$13.75



Sedgwick CMS
(formerly VPA)

Refer to the Short-Term Disability Summary Plan Document on the Benefits home page for further details.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

OTHER BENEFITS OFFERED

Auto, Home and Renters Insurance

You qualify for a special Maricopa County group discount on your auto, home and renters insurance through Group Savings Plus from Liberty Mutual. Payroll deduction is available. Contact Liberty Mutual directly to enroll.



Deferred Compensation

Your deferred compensation program is administered by Nationwide Retirement Solutions. This program allows you to defer a portion of your earnings each pay period into an account for your retirement. When you contribute a portion of your income, you reduce the amount that is taxable. You're not only saving for tomorrow, you're postponing federal and state income taxes today.

The maximum amount you can defer will be \$15,500 in 2008 if you're under 50. If you're 50 or over, your maximum is \$20,500 in 2008 or 100% of includible compensation, whichever is less. If you are within 3 years of retirement, you may qualify to contribute more if you have past dollars to "catch up". The minimum amount of deferral is \$10 per pay period. You have more than 35 investment choices as well as Personal Choice Retirement Account through Schwab that allows you to do other investing if you choose. You may also change your program at any time. And, as an added bonus, your money is available to you upon separation from County service with no early withdrawal penalty. For more information, call Margaret Volpe-Rodgers or Linda Pond at Nationwide.



Employee Assistance Plan (EAP)

Your Employee Assistance Plan benefit is offered by Magellan Health Services. All employees are automatically enrolled in this benefit that provides short-term counseling for both personal and work-related issues. Services are provided at no cost to the employee and his/her dependents. The EAP benefit also provides limited legal consultation and financial counseling.



MetLaw® Group Legal Services

Finding an affordably priced lawyer to represent you when you have trouble with creditors, buy or sell your home, or even prepare your will can be a challenge. Now there's a simple, affordable solution - Metlaw®, administered by Hyatt Legal Plans. MetLaw is a legal services plan that provides legal representation for you, your spouse and dependents at an affordable price.

Now you have a resource at your fingertips for important, everyday legal services. What's more, you'll also have someone to turn to for unexpected legal matters. With MetLaw, you can receive legal advice and fully covered legal service for a wide range of personal legal matters, including:

- Court Appearances
- Document Review and Preparation
- Debt Collection Defense
- Wills
- Family Matters
- Real Estate Matters
- Traffic Ticket Defense (except DUI/DWI)

This is just a partial list of services. For a complete list contact Hyatt Legal Plans at (800) 821-6400 or online at www.legalplans.com (password 1500518)

Services are provided from a network of experienced attorneys either on the phone or in person. When you use a Plan Attorney, there are no deductibles, copays, waiting periods, claim forms or limits on usage. You also have the flexibility to use a non-Plan Attorney and get reimbursed for covered services according to a set fee schedule.

The premium for this plan is \$7.87 per pay period, 24 pay periods per year.



Open Enrollment Worksheet

This worksheet will assist you while you are enrolling for your benefits online at my.maricopa.gov.

Complete this worksheet before you go online and use it to enter your open enrollment elections.

Remember to

- turn off your Caps Lock on your keyboard as passwords are case-sensitive
- make sure you did not enter any extra spaces in the password field
- submit your Open Enrollment elections by May 2, 2008 before 5 PM

If you have questions, contact your department
PC Help Desk or the Customer Support Center at
(602) 506-4357 between 6:30 AM - 6 PM, Monday-Friday,
excluding holidays, to reset your password.

The use of this system is restricted to authorized individuals.

Coverage	CIGNA Plan	Cost
<input type="checkbox"/> Employee only	<input type="checkbox"/> CMG High option	
	<input type="checkbox"/> CMG Low option	
<input type="checkbox"/> Employee+spouse	<input type="checkbox"/> OAP In-Network only	
	<input type="checkbox"/> OAP High option	
<input type="checkbox"/> Employee+children	<input type="checkbox"/> OAP Low option	
<input type="checkbox"/> Employee+family	<input type="checkbox"/> Choice Fund Health Savings Account	
<input type="checkbox"/> Waive Medical coverage for yourself and dependents (use only if covered under other group health insurance, proof required by May 30, 2008) <i>If you waive your medical coverage, you automatically waive behavioral health/substance abuse and pharmacy benefits.</i>		

Coverage	Plan	Cost
<input type="checkbox"/> Employee only	<input type="checkbox"/> Employers Dental Services	
<input type="checkbox"/> Employee+spouse	<input type="checkbox"/> CIGNA Dental	
<input type="checkbox"/> Employee+children	<input type="checkbox"/> Delta Dental	
<input type="checkbox"/> Employee+family		
<input type="checkbox"/> Waive Dental coverage for yourself and dependents		

VISION

Coverage	Plan	Cost
<input type="checkbox"/> Employee only	<input type="checkbox"/> Vision for medical plans*	\$0.00
<input type="checkbox"/> Employee+spouse		
<input type="checkbox"/> Employee+children	<input type="checkbox"/> Vision for medical waive**	
<input type="checkbox"/> Employee+family		
<input type="checkbox"/> Waive Vision coverage for yourself and dependents		
*If you chose a medical plan, you must enroll in Vision for medical plans		
**If you waived a medical plan, you may only enroll in Vision for medical waive or Waive Vision coverage		

HEALTH RISK ASSESSMENT	<input type="checkbox"/> Not taken	\$5.00	BIOMETRIC SCREENING	<input type="checkbox"/> Not taken	\$5.00
	<input type="checkbox"/> Taken	\$0.00		<input type="checkbox"/> Taken	\$0.00
	<input type="checkbox"/> Waive H.R.A.			<input type="checkbox"/> Waive Biometric Screening	
<i>If you waived a medical plan, you must choose Waive H.R.A. If you chose a medical plan, you may not waive H.R.A.</i>			<i>If you waived a medical plan, you must choose Waive Biometric Screening. If you chose a medical plan, you may not waive Biometric Screening.</i>		

Coverage	Plan	Cost
<input type="checkbox"/> Employee only	<input type="checkbox"/> Co-insurance	
<input type="checkbox"/> Employee+spouse		
<input type="checkbox"/> Employee+children	<input type="checkbox"/> Consumer Choice	
<input type="checkbox"/> Employee+family		
<input type="checkbox"/> Waive Pharmacy coverage for yourself and dependents <i>If you chose a medical plan, you must enroll in a pharmacy plan unless you chose Choice Fund HSA. If you waived a medical plan or enrolled in Choice Fund HSA, you must waive pharmacy.</i>		

Coverage	Surcharge	Cost
TOBACCO USE	Employee and / or family members	<input type="checkbox"/> Tobacco Use - Yes \$15.00 <input type="checkbox"/> Tobacco Use - No \$0.00
	<input type="checkbox"/> Waive Tobacco Use for yourself and dependents <i>If you or a covered dependent uses or have used a tobacco product in the last 6 consecutive months, you must respond as a Tobacco User. If you waived medical coverage, you must waive tobacco use.</i>	

GROUP LEGAL SERVICES	Cost
<input type="checkbox"/> Group Legal Services	\$7.87
<input type="checkbox"/> Waive Legal Services	\$0.00

BASIC LIFE & BASIC AD & D
No changes can be made. This an employer-paid benefit for 1X your annual salary

ADDITIONAL LIFE - EMPLOYEE ONLY
Employee: <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x
<input type="checkbox"/> Waive additional Life Insurance for yourself.
<i>*You may only increase one level without evidence of insurability*</i>

ADDITIONAL ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)
Employee: <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x
Employee & Family: <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x

DEPENDENT LIFE	<input type="checkbox"/> \$5,000	SPOUSE LIFE	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000 ²
	<input type="checkbox"/> \$10,000 ²		<input type="checkbox"/> \$30,000 ²	<input type="checkbox"/> \$40,000 ²
	<input type="checkbox"/> \$15,000 ^{1,2}		<input type="checkbox"/> \$50,000 ²	<input type="checkbox"/> \$60,000 ^{1,2}
	<input type="checkbox"/> \$20,000 ^{1,2}		<input type="checkbox"/> \$70,000 ^{1,2}	<input type="checkbox"/> \$80,000 ^{1,2}
	<input type="checkbox"/> Waive Dependent Child Life		<input type="checkbox"/> \$90,000 ^{1,2}	<input type="checkbox"/> \$100,000 ^{1,2}
¹ Evidence of insurability required for initial election; ² Evidence of insurability also required for any increase in coverage after initial election.		¹ Evidence of insurability required for initial election; ² Evidence of insurability also required for any increase in coverage after initial election.		

SHORT - TERM DISABILITY
<input type="checkbox"/> 40% <input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70% <input type="checkbox"/> Waive


FLEX SPENDING HEALTH CARE
\$5,200 plan year limit
<input type="checkbox"/> FSA (Flexible Spending Account) Health Care \$ _____
<input type="checkbox"/> Limited Use FSA for Choice Fund Health Savings Account \$ _____
<input type="checkbox"/> Waive Flex Spending Health Care
<i>Please Note: Do not enroll if you are wanting to make a contribution to a health savings account. This can't be done in the system. Call (602) 506-1010 for more information.</i>

FLEX SPENDING DEPENDENT DAY CARE
\$5,000 calendar year limit
<input type="checkbox"/> Dependent Day Care FSA - Yes \$ _____
<input type="checkbox"/> Dependent Day Care FSA - No

SUBMIT
You must click on the "Submit" button to finalize your benefit elections.

Remember to Print
Go back to your submitted Open Enrollment event and print the "Enrollment Summary" page. Keep it to compare with your confirmation statement you'll receive in mid-June.

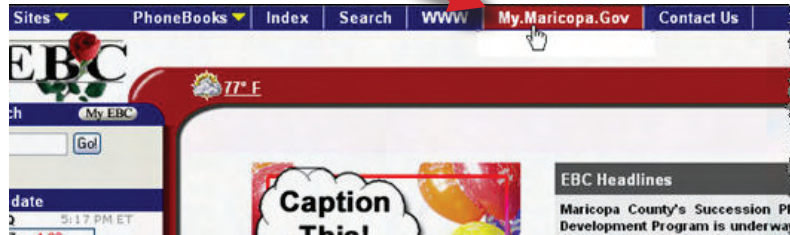
ONLINE EMPLOYEE SELF SERVICE INSTRUCTIONS

1. Start your browser by double clicking the  on your desktop.

2. In the address line in the browser, type my.maricopa.gov and press “Enter” on the keyboard

-or

from work, access the Intranet click on the My.Maricopa.Gov button at the top of the EBC home page (<http://ebc.maricopa.gov>)



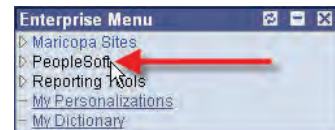
3. At the initial PeopleSoft login screen, enter your user ID and password and click the “Sign In” button or hit “Enter” on the keyboard.

User ID:

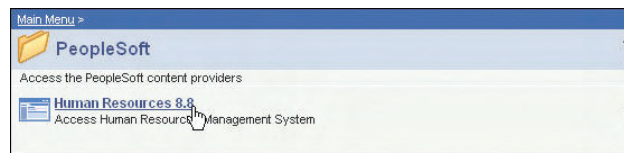
Password:

(if you do not know your ID or Password, call your department PC Help Desk or the Customer Support Center at 602-506-4357)

4. After successfully logging in, click on “PeopleSoft” located in the menu on the left of the page.

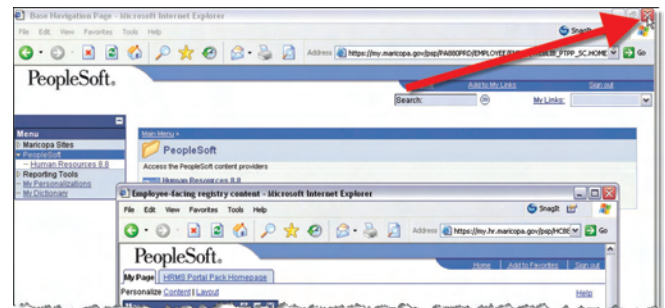


5. Click on “Human Resources 8.8”

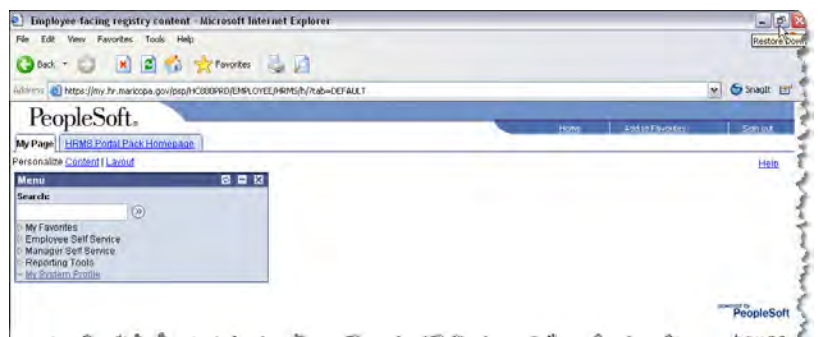


6. A new PeopleSoft page will open.
Close the first window.

If you do not close the initial PeopleSoft page, you will be timed out after 20 minutes and may lose your selections.



7. You now have one PeopleSoft page open with a Menu similar to the one displayed. You may need to enlarge the page to fully view the menu and options (Press F11 on your keyboard to view the page full screen).

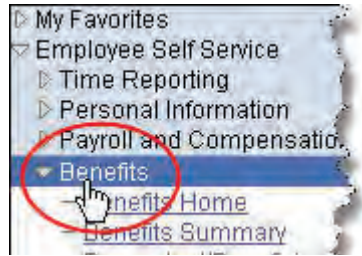


8. At the Menu...

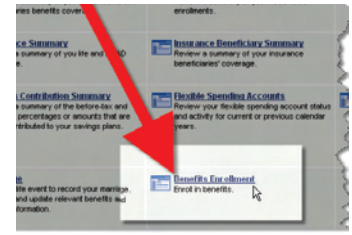
Click on "Employee Self Service"



Click on 'Benefits'



Click on "Benefits Enrollment"



9. You may now begin the Enrollment process.
To begin, click on the "Select" button.

Open Benefit Events			
Event Description	Event Date	Event Status	
Open Enrollment	06/29/2008	Open	Select

10. Go through each option listed in the Enrollment Summary in the order they are listed. To view your medical and other benefit options, click the "Edit" button to the left of each option.

Enrollment Summary			
		Before Tax	After Tax
Edit Medical	Current: Choice Fund HSA:Emp+Spous		
	New: Choice Fund HSA:Emp+Spous	0.00	
Edit Dental	Current: Delta Dental Emp+Family		
	New: Delta Dental Emp+Family	34.24	
Edit Vision	Current: Vision for Medical Plans:Emp+Spous		
	New: Vision for Medical Plans:Emp+Spous	0.00	
Edit Health Risk Assessment	Current: HRA:NOT TAKEN		
	New: HRA:NOT TAKEN	5.00	
Edit Biometric Screening	Current: Biometric Screening:NOT TAKEN		
	New: Biometric Screening:NOT TAKEN	5.00	
Edit Pharmacy	Current: Waive		
	New: Waive	0.00	
Edit Tobacco Use	Current: Tobacco User- No:NO		
	New: Tobacco Use:NO	0.00	
Edit Group Legal Services	Current: Waive		
	New: Waive	0.00	
Edit Basic Life and AD&D	Current: Basic Life: 1 * Salary		
	New: Basic Life: 1 * Salary: \$60,000	0.00	
Edit Additional Life	Current: Addt LF 5x: 5 * Salary		
	New: Addt LF 5x: 5 * Salary: \$300,000	10.50	
Edit Additional AD&D	Current: FM ADD 5x: 5 * Salary		
	New: FM ADD 5x: 5 * Salary: \$300,000	5.25	
Edit Dependent Child Life	Current: Dependent: Children Life \$10K		
	New: Dependent: Children Life \$10K	0.50	
Edit Spouse Life	Current: Spouse Life \$50K: \$50,000		
	New: Spouse Life \$50K: \$50,000	2.50	
Edit Short-Term Disability	Current: Short Term Disability 70%: 70% of Salary		
	New: Short Term Disability 70%: 70% of Salary	32.61	
Edit Flex Spending Health Care	Current: Limited use FSA for CFHSA: \$1,625.00		
	New: Limited use FSA for CFHSA: \$1,625.00	67.71	
Edit Flex Spending Dependent Care	Current: Waive		
	New: Waive		

11. Make sure to review the "TOBACCO USE", "HEALTH RISK ASSESSMENT", and "BIOMETRIC SCREENING" elections and answer the questions accurately. This is the area where you indicate your eligibility for the wellness incentives.

12. You must click on **two "SUBMIT" buttons** to complete your enrollment. After making all benefit elections, click on the "Submit" button at the bottom of the page. On the next page, click on the "Submit" button at the bottom of the page to send your final choices to the EHI Department.

EXAMPLE

documents and contracts that govern the plans. If there is this system and the official documents, the official documents.

Important:

Your enrollment will not be complete until you Submit elections, click the Submit button.

[Submit](#) Click **Submit** to send your benefit choices to the Enrollment Summary.

[Enrollment Handbook](#)

[Click to Print This Page](#)

Enrollment Summary

[Edit](#) **Medical**

Current: Open Access Plus In-Ntwrk Only:Emp+Family

New: Open Access Plus In-Ntwrk Only:Emp+Family

[Edit](#) **Dental**

Current: CIGNA Dental:Emp+Family

New: CIGNA Dental:Emp+Family

[Edit](#) **Vision**

Current: Vision for Medical Plans:Emp+Family

New: Vision for Medical Plans:Emp+Family

[Edit](#) **Health Risk Assessment**

Benefits Enrollment

Submit Benefit Choices

John Doe

You have not completed your enrollment.

If you have no further changes, read the "Authorization Statement" and then click **Submit** at the bottom of this page to finalize and save your benefit choices.

[Cancel](#) Click **Cancel** if you are not ready to submit your choices and wish to return to the Enrollment Summary.

Do not submit your benefit choices until you have completed all of your open enrollment elections.

Once you've submitted your elections, you can return to your Open Enrollment event and make changes to those previously submitted. Your open enrollment ends on May 14, 2007, you will not be able to make any further benefit changes until the next Open Enrollment period.

Once you have submitted your final benefit elections, you'll need to come back into your open enrollment event and print out the Enrollment Summary page so you have verification of your benefit elections. You can save this page to compare to the confirmation statement you'll receive in mid-June. In case of an error, you can use your copy of the Enrollment Summary to have your benefits corrected.

Authorization Statement

By submitting my benefit choices to the Enrollment Summary, I authorize the Enrollment Summary to use my selected vendors to provide and support my coverage.

By submitting my open enrollment request to continue with my current health care coverage, I understand and agree that Maricopa County may share protected health information (PHI) concerning me and my dependents, as described in the Maricopa County Notice of Privacy Practices, with my health care providers which could include CIGNA HealthCare of AZ and CIGNA Dental. My health care providers (PHI), Maricopa Health Services, Delta Dental, Employees Dental Services (EDS), The Standard Life, CIGNA Vision Care, Sedgwick Claims, Application Software Inc. (the flexible spending account administrator) and CIGNA, Maricopa Health, CIGNA Vision Care and others in their role as plan administrator. I further agree to authorize Maricopa County and Maricopa County's health care providers for any good faith reasons of PHI in connection with my benefits as so otherwise authorized or required by law.

By updating and submitting your beneficiary elections through PeopleSoft, you are making an electronic signature in accordance with applicable state or federal law. This signature is the equivalent of a manual signature.

By submitting my elections, I certify to the best of my knowledge all information I have provided is accurate, correct and complete. I understand that I may be subject to disciplinary action up to and including termination for failing to provide accurate and complete information. I further understand and agree that I will be required to reimburse Maricopa County for any additional premiums and the cash-out claims which as a result of processing inaccurate, incorrect or incomplete information.

[Submit](#) Click **Submit** to send your final choices to the Benefits Office.

[Cancel](#) Click **Cancel** if you are not ready to submit your choices and wish to return to the Enrollment Summary.

This table summarizes estimated costs for your new benefit choices.

	Before Tax	After Tax	Total
Your Costs	111.95	51.36	163.31

These costs do not include certain choices that are based on variable earnings.

[Submit](#) Click **Submit** to send your benefit choices to the Benefits Office.

13. Once you have submitted your final benefit elections, go back into your event and "print" the benefit enrollment summary page so you will have verification of your benefit elections. Use the printed summary page to compare to the confirmation statement you will receive from your department's HR Liaison. In case of an error, you can use the printed enrollment summary page to have your benefits corrected.



WHO TO CONTACT

Maricopa County Employee Health Initiatives Department

(Benefits Office)

Maricopa County Administration Building

301 West Jefferson St., Suite 201

Phoenix, Arizona 85003-2145

(602) 506-1010

Fax: (602) 506-2354

TTY: (602) 506-1908

EH Home { www.maricopa.gov/benefits

Pages { <http://ehc.maricopa.gov/ehi>

BenefitsService@mail.maricopa.gov

Medical Plans

CIGNA - Group #3205496

Customer Service - (800) 244-6224

Pre-Enrollment Questions - (800) 401-4041

24-Hour Health Information Line - (800) 564-8982

Well Aware Disease Management - (800) 249-6512 to enroll

or (877) 888-3091 for questions

Healthy Babies - (877) 244-6224

Healthy Rewards - (800) 870-3470

www.cigna.com

www.mycigna.com

www.mycignaplans.com

(username: Maricopa2008 / password:cigna)

Pharmacy Plans*

Walgreens Health Initiatives - Group #512229

Member Services - (800) 207-2568

Prior Authorization - (877) 665-6609

Walgreens Mail Service Member Service - (888) 265-1953

Mail Service Refills - (800) 797-3345

Specialty Pharmacy - (888) 782-8443

www.mywhi.com

Behavioral Health / EAP*

Magellan Health Services - Group# N/A

(888) 213-5125

www.magellanhealth.com

Vision

EyeMed Vision Care - Group #9690793

Customer Service - (866) 724-0782

Pre-Enrollment Questions - (866) 723-0596

LASIK - (877) 552-7376

www.eyemedvisioncare.com

emvision@eyemed.sento.com

Dental

Employers Dental Services - Group #11931-Plan #300R

(602) 248-8912 or (800) 722-9772

www.mydentalplan.net

CIGNA Dental - Group # 2465354

(888) 336-8258

www.mycigna.com

Delta Dental - Group # 4500

(602) 938-3131 or (800) 352-6132

www.deltadentalaz.com



Life Insurance

The Standard - Policy #645547

(888) 414-0396

www.standard.com/mybenefits/maricopa

Short-Term and Long-Term Disability

Sedgwick CMS - Group# **435000**

Short Term Disability - (800) 599-7797

Long Term Disability - (800) 495-9301

www.sedgwickcms.com/calabasas

Retirement

Arizona State Retirement System - (602) 240-2000

Outside Phoenix - (800) 621-3778

www.azasrs.gov/web/index.do

Public Safety Retirement System

(602) 255-5575

www.psprs.com

Nationwide Retirement Solutions:

Deferred Compensation

(602) 266-2733

(800) 598-4457

www.maricopadc.com

Other

ASI - Group #455

Mariflex (Flexible Spending Accounts)

(800) 659-3035

www.asiflex.com

asi@asiflex.com

Liberty Mutual: - Group #8871

Auto, Home and Renters Insurance

(800) 221-8135

www.libertymutual.com

MetLaw® - Plan 150 / Group #0518

(800) 821-6400

www.legalplans.com (password - 1500518)

Compusys

COBRA Administrator

(602)-234-0497

(800) 933-7472

mccobra@cserisa.com

Biometric Screening Administrator:
Employee Health Management Systems

(480) 827-2277

www.ehms.com

*Contact CIGNA for pharmacy & behavioral health for the Choice Fund HSA plan